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IN MEMORY OF SIGMUND FREUD

As a modest contribution to the world-wide observance by the medical and social sciences of the centenary of the birth of Sigmund Freud, THE PSYCHIATRIC QUARTERLY is dedicating this issue, October 1956, to his memory.

At the invitation of this journal, Francis J. Braceland, M. D., president of the American Psychiatric Association, has contributed a short introductory article on the significance of Freud's work to modern psychiatry; Samuel R. Lehrman, M. D., associate editor and psychoanalyst, has written, at the invitation of the editor, a theoretical discussion with clinical examples, of a subject whose study was inspired by Freud. The eighth annual Hutchings Memorial Lecture (in honor of a pioneer of psychoanalysis), delivered by Director Lawrence C. Kolb, M. D., of the New York State Psychiatric Institute, is included to trace the development of modern psychotherapy from classical psychoanalysis.

A paper on psychoanalytic anthropology by S. H. Posinsky, Ph. D., equating money and "pains" in a strongly anal American Indian culture, represents Freud's interests and his pioneer endeavors in the non-medical social sciences, for which he personally trained more than one distinguished field worker. Another paper, this one on a theoretical subject which psychoanalysis has raised to one of great practical importance, is a contribution to forensic psychiatry on "Intent" by Fred Mettler, M. D.

Throughout his career, Freud expressed the strong hope that somatic measures would some day be found to shorten the difficult psychotherapeutic road to mental health. In this spirit this QUARTERLY includes a paper on drug research by Sidney Malitz, M. D., and Commissioner Paul H. Hoch, M. D., of the New York State Department of Mental Hygiene, one on the side effects of chlorpromazine and reserpine by Anthony A. Sainz, M. D., and one on resistance to lysergic acid in schizophrenic patients by Herbert S. Cline, M. D., and Harry Freeman, M. D. In an informal first-person report of a World Health Organization tour, Assistant Commissioner Robert C. Hunt, M. D., of the New York State Department of Mental Hygiene, writes of mental institutional administration today—both at home and abroad. Freud would have been interested and heartened by his survey.

SIGMUND FREUD: 1856-1956*

BY FRANCIS J. BRACELAND, M. D., Sc. D.

Dates mean relatively little in the long history of psychiatry, for the growth of knowledge has been so gradual, so interwoven with previous conceptions and misconceptions, successes and failures, that sharp dividing lines between decades and centuries are scarcely distinguishable. The dates that stand out most boldly in the pages of time have to do with such events as the unfettering of patients by Pinel at the Salpêtrière, the founding of our mental hospitals, the identification of major organic and functional disease pictures, the development of specific and empirical treatments —most of them, alas, still faulty and incomplete.

Other dates mark the birth of great men. Of these, one, and indeed the most significant so far, is the year 1856, the birth date of Sigmund Freud and also of Emil Kraepelin. To many of us, Kraepelin is already a shadowy figure, though he was a pioneer of noble proportions. Freud, however, continues to be such a powerful force in the world of ideas that it is difficult to realize that he died almost two decades ago. In the interval we have seen advances in psychiatry along many different fronts. We have seen a substantial growth in theory and method. We have seen great advances in psychotherapy and in physical methods of treatment. We have seen the startling effects of hallucinogenic agents on normal individuals, and of tranquilizing drugs on the psychotic. We have seen the surge of social psychiatry. But we have also seen the rich production of psychoanalysis, and we are mindful each day of the magnitude of the work of Sigmund Freud and its inexhaustible implications for the medical and social sciences.

Clinical psychoanalysis was introduced into America 50 years ago. Here, more than elsewhere, psychoanalysis has developed in the framework of medical practice. Freud was not altogether satisfied that this should be so. In fact, he referred to it as "medical fixation," as a watering down of psychoanalysis, and suggested that this was a mistake inasmuch as the structure of the science was far from firmly established. In his view the findings and theories

*Contributed by Dr. Braceland, as president of the American Psychiatric Association, at the invitation of this QUARTERLY to take part in its observance of the 100th anniversary of the birth of Sigmund Freud.

of psychoanalysis should be subject to repeated verification and confirmation. The discipline would, therefore, evolve most appropriately in its own environment, free from the impingement of other sciences. This view did not mean that Freud doubted the eventual discovery of a physical groundwork for psychology. Let the biologists go as far as they can, he would say, and let us go as far as we can—some day the two will meet. It seems fairly clear now that the clinical use of psychoanalysis and of psychoanalytic concepts, and their integration in all of medicine, will do more than anything else to bring about this rapprochement.

The work of Freud forged a new technique for uncovering the etiological factors in mental illness. This is more important than the great nosological conceptions which set a baseline for the major neuroses as important as that drawn by Kraepelin for the functional psychoses. Freud gave sense and meaning to both neurotic and psychotic symptoms, and showed their relations to different levels of the psychic economy. Prior to Freud, or at least prior to the acceptance of his discoveries, it was thought that a major psychosis had to be of organic origin and that the personality of the patient, his environment, his history, his relationships, had fundamentally little to do with it. Freud demonstrated that personality formation and personal experience did have much to do with it. Though he doubted the usefulness of psychoanalysis in the treatment of psychotic patients, the psychoanalytic approach to the treatment of functional psychoses, particularly schizophrenia, has proved to be feasible and sometimes successful. This is, indeed, one of the most promising areas of psychoanalytic research.

The psychoanalytic orientation has illuminated the behavior of man as an individual and as a member of ethnic or social groups. It has revealed the impact of the unconscious on normal and abnormal behavior and the integration of the irrational with all that is rational in the human mind. Psychoanalysis has clarified problems of functional somatic symptoms based upon the emotions. It has formulated and enriched the doctor-patient relationship. It has made possible a science of child growth and development, thus opening new possibilities for mental hygiene. It has changed the attitude of the psychiatrist toward his patients, lightening the burden of constitution, deterioration, and organic determination, which weighed upon them and him for more than a century. Psy-

choanalysis directed attention to personality formation, to environment, to interpersonal relations, to goals, values and cultural forces—all entering into the composition of mental illness and into the program for combating it.

The wide influence of psychoanalysis stems from the living, moving, human character of the method, which delves into the very sources of human emotion. It is geared to the humanities as well as to the sciences, to philosophy and literature and art and other areas of human expression. Many disciplines are working in cooperation to provide an exhaustive view of human behavior. As we contemplate the scene during this centennial of the birth of Sigmund Freud, we find that the work of the great explorer is being used as a basic ingredient of the synthesis toward which all are striving.

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REACTIONS TO UNTIMELY DEATH

BY SAMUEL R. LEHRMAN, M. D.

Scientific psychiatric interest in grief and other reactions to actual loss of a loved person through death stems from the psychoanalytic investigation of pathological depressions. Abraham,[1] in 1911, noted the similarity in psychic structure between manic-depressive depressions, involutional melancholia, and neurotic depressions, and was the first to point out the marked structural similarity of depressive psychosis to obsessional neurosis. Freud,[2] in 1916, amplified Abraham's observations in the classic paper "Mourning and Melancholia." He introduced the concept of mourning as a process, noted the similarity between mourning and melancholia, and was able to show the structural difference between the two conditions. "Mourning is regularly the reaction to the loss of a loved person or to the loss of some abstraction which has taken the place of one, such as fatherland, liberty, an ideal, and so on. As an effect of the same influences, melancholia, instead of a state of grief, develops in some people . . ." Freud demonstrated that the psychopathology of melancholia revolved around introjection of the love object with a feeling of loss of love due to ambivalence and to sadistic attack on the introject.

Other writers have commented and enlarged on various aspects of Freud's work. Abraham[3] emphasized the pregenital stages of the libido in depressions, and introduced the concept of "primal depression." Rado[4] stressed the blows to narcissism, and endeavored to evolve the plan of interaction between the separate mental phenomena and their origin. He considered melancholia to be "a despairing cry for love" and postulated an "alimentary orgasm" which followed nursing. Melanie Klein's formulations[5] marked the "infantile depressive position" in the first year of life. There is a decided similarity to Freud, Abraham, and Rado, but she places the development of the psychic structures of the mind much earlier than they (first year of life), and considers the various "positions" to be self-preservative defensive measures. Gero,[6] and Jacobson[7] also stress the importance of disappointment in childhood, but underline the role of the Oedipal conflict. Lewin,[8] in his brilliant book, *The Psychoanalysis of Elation,* has summarized the literature on depression and elation, and emphasized the "oral triad"

in these conditions ("a wish to eat, a wish to be eaten—to enjoy a yielding relaxation—, and a wish to go to sleep").

Other authors, unlike the foregoing who were primarily interested in the manic-depressive conditions, have written of individual reactions to the death of a loved one. Helene Deutsch[9] described cases where the patients reacted to both timely and untimely death with "absence of grief." Charles Anderson[10] described pathological grief reactions among men suffering from war neuroses. Stern, Williams and Prados[11] described several "grief reactions in later life." Martin Peck[12] presented at length the case history of a 40-year-old man who developed a depression on learning of his wife's incurable illness, and whose psychoanalytic treatment extended over a period which included her death. Peck's patient presented a depressive reaction to untimely death. A. A. Brill[13] presented a case report of a man who reacted to the untimely death of his wife with a manic attack, following a mild depression.

The phrase "untimely death" refers to a death which occurs in a relatively young person. It also implies a disadvantageous timing in its occurrence. The death may be actual and sudden; or the pronouncement of incurability, serving as a death sentence, may usher in the reaction (cf. Peck's case). There is frequently surprise, shock and lack of preparation. On ordinary condolence calls, one inevitably hears the cliché: "When death occurs it is always a shock, no matter how well prepared you are . . ." This is a conventional utterance with euphemistic, ego-defensive intent; it is not true. Grief reactions are actually much more normal when death occurs in an aged person and has been expected. Under such circumstances the work of mourning is done quickly, because a certain amount of this work (detaching the libido from the object) has already preceded the event of death. Pathological reactions to death are more frequent when the death is untimely and sudden. Other conditions also contribute to the formation of these pathological reactions.

The present paper is concerned with some variants of pathological reactions to untimely death, their origin, and meaning. The clinical material consists of five case histories. In two of the cases (Case 1 and Case 5) a young husband died suddenly of a heart attack. In one case, a 35-year-old woman learned that her best

friend had been found to have an incurable disease. In another, a mother lost her 22-year-old son. In Case 4, a woman who came for treatment for a postpartum depression revealed the connections of this reaction with her reaction to her father's untimely death when she was four years old.

Case Material

Case 1

A 40-year-old widow was seen in consultation at a general hospital. She had taken a bottle of "sleeping pills" and then had called her family doctor and told him about it. One year before, her husband had died suddenly of coronary thrombosis. She stated that she had "felt too shocked to cry" (absence of grief), but subsequently she felt lost. She felt very lonely and would often cry herself to sleep. She thought of suicide often, but was kept from action by a sense of responsibility to her three children. The estate left to her was small and she worked to supplement her income, but she was not happy working and sought marriage. A few weeks after the husband's funeral she began to go out on dates, but was distressed that middle-aged marriageable men were more interested in sex than in marriage. A widower with children proposed, but she considered the marriage impossible for "financial" reasons.

Her suicide attempt was a reaction of disappointment in her relations with another man. She had gone to his apartment in the course of establishing a permanent relationship with him, and was disturbed when he failed to call her during the following week. Her (oral) demanding expectations were characteristic of her relations with her husband, toward whom she had always felt ambivalent. Her castrative aggressiveness toward him was revealed in sexual frigidity and in interference with his business progress. She stated, "My husband has always been a passionate man, and I've always been an affectionate *man*" (the slip of the tongue further reveals penis envy). Her mother had come to live with her after her husband died, and this increased her super-ego and dependency conflicts. When she started to "date" at an age approaching 40, her social rustiness contributed to severe narcissistic injury. Her attitude toward the friend who was the occasion of the suicide attempt was similar to, and in some respects repeated, her at-

titude toward her husband. Her reaction to her husband's untimely death was close to one of "absence of grief," but the suicide attempt undoubtedly contains unresolved residuals of the reaction.

Case 2

A 35-year-old married woman, the mother of two children, was referred for psychiatric treatment because of a number of physical complaints for which no organic basis could be found. She presented a chief complaint of, "I have pain." This pain occurred in the back, in the thoracic and lumbar regions. She said that it had started with an epigastric spasm approximately a month after she had learned that her best friend had an incurable disease. Her aging mother, too, had developed a chronic illness. The patient's history included an "ulcer spasm" about 12 years before, and a severe depression, with successful psychiatric treatment, about 10 years before her present illness. She had had claustrophobia of varying severity since childhood. There were also compulsions and obsessions. Up to the time of her present illness she had made an excellent social adjustment, but with considerable anxiety. Her illness served the secondary gain of relieving social pressure; understandably she was much distressed if anyone commiserated with her.

Following a difficult pregnancy with her second child (sacroiliac strain, threatened abortion, and severe hemorrhoids), she was advised to avoid pregnancy. This proscription (=castration) called forth defensive measures against feelings of inferiority. She had always avoided contraceptive responsibility and the authoritative medical advice, added to her previous prudishness, justified increased reluctance to have sexual intercourse. Intercourse usually took place after an evening of "social" drinking. During the course of treatment, she blamed her husband for all her difficulties, and she clung tenaciously to the position of a wronged wife.

This attitude had been carried over from childhood. Her mother had always been afraid of illness and of doctors, and had adopted an ostrich attitude when the children were sick, so that the patient was seriously neglected in childhood. Her friend's condition had been early misdiagnosed, and when the correct diagnosis was made, it was too late. The patient's attitude toward doctors, her husband and her friend contained much ambivalence with marked (re-

pressed) aggression and identification originating in maternal transference. The actual death of the friend was of small significance, although the patient cried at the funeral. The conversion symptoms, connected as they were with identification and introjection, served the purpose of warding off a deep depression and possible suicide. They continue to be operative, but with decreasing intensity.

Case 3

A 41-year-old married woman, the mother of three children, was referred for psychiatric treatment because of persistent pain in the right knee and leg. She presented as a chief complaint, "I haven't been the same since my son had his leg amputated." This had occurred about a year before her first visit, and she dreaded the approaching anniversary. The son had died six months after the operation and the patient experienced much grief (painful affect, loss of interest in the outside world and inability to love or be loved). However, she felt it necessary to withhold her tears at the funeral or when her family was watching, and she cried only in secret. When her aged father died, some time later, the patient said she could feel nothing.

The patient was the third of four children with immediately older and younger brothers. She had been brought up in a puritanical atmosphere and had married early, naïve and inexperienced. Her sex life was dull, but she soon became pregnant and was able to obtain great joy from identification with her son. (Conversely her daughters were a constant trouble.)

There were no overt phobias or obsessions, but the patient presented features of a mixed hysterical and compulsive character. She was perfectionistic, exacting and punctual, and had a need for affection and dramatic action. Her penis envy, disguised by reaction formation, appeared in her ambivalence toward husband, children and her career. She reacted to her son's leg-amputation with conversion symptoms which warded off feelings of guilt linked to her aggression, the pain of penis envy, and grief over the loss of the son with whom she identified. The reaction formation of love for her son (carried over from her brothers) failed when he lost his leg. The narcissistic injury caused by symbolic castration increased her aggressions and guilt and doubled the ego-defensive burden of identification. These mechanisms contin-

ued after the son's death. Suicidal impulses appeared, and she could only react to her father's more timely death (which was insult added to injury) with absence of grief. This reaction was different from not crying at the son's funeral. There she defiantly (aggressively) displayed her "masculine" strength. The absence of grief was due to further regression. The conversion symptoms disappeared during treatment in which she was encouraged to cry and to share her grief with her husband. She discontinued treatment as the underlying neurotic character structure became exposed.

Case 4

A 26-year-old married woman was referred for treatment because of a postpartum depression. She had married against her mother's advice and had developed a markedly dependent attitude toward her mother-in-law. The birth of her son had aroused in her a considerable amount of latent sibling rivalry. (Although an only child, she had been a pupil in her mother's school class.) Further narcissistic injury resulted from the expectation of her mother-in-law that she care for her child. In the course of analysis the development of her obsessive-compulsive and depressive trends unfolded. Her mother, a schoolteacher, had toilet-trained her early, abandoned her to a housekeeper, and returned to work, but at the insistence of the father, a moderately successful engineer, had stopped working when the child was two years old.

The father had wanted a boy, but had been extremely affectionate until his death when the patient was four years old. The patient lost an important source of narcissistic supplies at the onset of the Oedipal period, and the injury was compounded when her mother again returned to work, this time out of necessity. The patient sought to please her mother and other caretakers, and learned that she could keep her mother at home by becoming ill. She developed into a markedly obsessive-compulsive character with asthma, skin allergies and depressive trends. With considerable emotional conflicts, she competed successfully with the children in her mother's class and developed an attitude of overvaluation to money and intellect. To be wealthy, meant that mother would love her, since mother paid more attention to the other (wealthy) children in the private school where she taught; this also meant that mother's approval was determined by her at-

titude toward feces during toilet-training. The patient's giving birth to her own child reactivated this complex (cf. the equation: child=feces=money[14]). The intellectual interests originating in oral and anal levels (identification with mother and *her* compulsiveness) were reinforced by penis envy at the Oedipal level. The child reacted to her father's death with a repetition of her earlier response to loss of her mother, reinforcing the development of depressive and obsessional trends. This case represents a prime example of Abraham's early observation of the relations between depression and obsession-neurosis, and of Jacobson's observations[7] of the interrelations of the Oedipus complex with depressions.

Case 5

A 27-year-old married woman, the mother of two sons, presented a chief complaint of "I have an empty feeling, nothing to live for." She thought her difficulties had started about a month before her initial visit when her husband gave her a gold cupid for a charm bracelet as a birthday present. The patient did not realize the value of the gift and considered it to be a joke. This offended the husband and he showed his temper publicly. The patient said she "cried hysterically and felt something snap." Her immediate history is relevant to this reaction. Following an appendectomy, pulmonary embolism and subsequent miscarriage, she was told to avoid pregnancy (cf. Case 2) because of a tendency to thrombophlebitis. She craved a "tiny baby" and especially a daughter. The gold "baby" was, therefore, felt by her as a mockery, and the repressed anger burst through the censorship.

The patient had been the first-born to undemonstrative, obsessional parents. She was brought up largely by "nurses" and maids. She resented the arrival of her siblings, but managed her hostility through partial repression and reaction formation. Although she was attractive and talented, her childhood and adolescence were unhappy. It was an achievement that she married the man she loved when she was 19. She disregarded her slight phobias and compulsiveness when they were uncovered during her treatment.

The patient improved under psychotherapy. She related to the therapist, and was able to verbalize, and accept, a small amount of hidden resentment toward her husband. Doubt was thrown on her magical beliefs (that she was being punished for past sins

by being denied a third child) when her internist granted her permission to try to become pregnant. Two months after she became pregnant, at a time when discussion of terminating her treatment was taking place, her husband developed a benign subacute illness which confined him to bed for two months. During this time, the patient became obsessed with the idea that he would die and that she was being punished—partly for past misdeeds, and partly because this was her husband's way of disapproving of pregnancy. (The intimation of couvade could not be avoided. She said, "He always gets sick whenever I'm pregnant.")

A week after his recovery, while his six-months-pregnant wife was jubilantly planning a party to celebrate it, the man suddenly dropped dead. The patient was acutely shocked. She screamed and cried and then withdrew and denied the occurrence. She was heavily sedated and was seen by the writer on the following day. The reaction of apathy and denial continued. It was insisted that she attend the funeral where she wept bitterly. During the mourning period which followed, she remained in bed, refused religious ministry or any other attempt at solace, but was not averse to being seen by the writer daily. She was withdrawn from her children, but was able after a few weeks to be up and about. She abjured cosmetics and ate poorly. Treatment was directed at encouraging her to grieve, with particular emphasis on the reality aspects of her situation.

Three months after her husband's death, she gave birth to a daughter. About a month after leaving the hospital, she gave up her home and moved her family to her parents' home. Her mother seemed understanding, but her father pressed her "to snap out of it." She continued with her psychotherapy, but became much attached to a woman relative slightly older than herself. She seemed to be working through the mourning, but received a marked setback from a relatively minor event. Her relative (mother surrogate) took a short vacation with her husband; the patient reacted to it as though she had once more been abandoned. She (again) stopped eating—with suicidal intent, and became more and more emaciated. Ambulatory insulin therapy at home and in a general hospital produced no particular effects. She began to talk about distortion in the size and appearance of her hands. After the writer had consulted with a colleague, about a week after

admission to the hospital, electric convulsive therapy (ECT) was begun.

The administration of ECT was preceded by an intravenous injection of sodium amytal. As a consequence of the combined treatment the patient was able to sleep well for the first time in many weeks. Her reaction to the writer was interesting. She wanted to know "why Dr. Lehrman didn't give the treatment," and she greeted him by saying she "was mad" at him for not being present (even though he had been present). The meaning of this is clear when seen in the light of maternal transference. Although it seemed as if the patient had erotized the relationship to the writer in a genital way, this was not wholly the case. She was expressing anger at her mother for not taking care of her and was saying: "Mother (Dr. L.) should remain with me, feed me, nurse me and put me to sleep" (cf. Lewin[8]). The distortion in hand size was related to her having been slapped by her piano teacher for "bad playing," and represented guilt over masturbation. Her reaction to her husband's untimely death was determined by her early relations with her mother, since her marriage relationship had been maintained largely on a pregenital level. She had carried over to her husband an ambivalent reaction formation (sibling rivalry), and an oral-anal dependency which originated in the infantile ambivalent attitude toward mother and caretakers. These feelings became obtrusive when she felt rejected by him. Her initial depressive reaction underwent further regression toward narcissistic withdrawal as a consequence of severe reality shocks which combined with the internal mechanisms to overwhelm the ego. A full course of ECT was disappointing in its results. After alternating periods of apathy and manic agitation, the patient was hospitalized in a distant city and gradually recovered.*

Discussion

Reactions to untimely death may be considered to be variants of grief reactions. They differ from ordinary grief reactions in that the ego is less prepared for the loss, and in that the actual threat to the patient's ego is much greater. This external threat

*The mechanism of anorexia in this case may be compared to that described by Gero (Ref. 15). The writer has also observed obesity which developed in two adolescent girls as depression-equivalents in response to death of the father.

activates previously conditioned internal sado-masochistic impulses. Other conditions contributing to the formation of these pathological reactions are: previously existing psychopathology in the mourner, weakness of the ego, and absence of compensations in substitute love objects. Those patients who would tend to develop depressions (in the absence of death loss), or pathological grief reactions to expected or timely death, would inevitably develop pathological reactions to untimely death. It cannot be said, however, that pathological reactions to untimely death are only depressions or depression-equivalents, although prolonged dejection often appears as part of the clinical picture. Conversion hysteria is frequent enough to suggest one meaning for the heretofore confusing lay description of tears as "hysterical."

Even in situations of *timely* death, Helene Deutsch[9] has shown that when the ego feels threatened it may attempt to protect itself by absence of grief. (She feels, however, that ultimately the work of mourning must be done.) Her study confirms that of Freud, in ascribing great importance to the degree of persisting ambivalence and guilt feelings toward the lost love object. She gives as motives for exclusion of affect: (1) unendurability because of the ego's weakness—as in children, (2) submission to other claims of the ego, especially through narcissistic cathexis, (3) previously existing conflict with the lost object. She indicates that grief may take various forms, but her main thesis is that "the process of mourning as reaction to the real loss of a loved person must be carried to completion." Her patients, like those described in the present paper, reacted in accordance with their childhood conditioning, in further clinical confirmation of the genetic principle in psychoanalytic theory.

Anderson[10] studied 100 cases of morbid grief and classified the reactions in the following clinical patterns: anxiety states 59 per cent, hysterias 19 per cent, obsessional tension states 7 per cent, and manic-depressive responses 15 per cent. He observed that these reactions "were neither pure in type nor static," and that the clinical picture changed as the work of mourning proceeded. His case examples were all war neurotics who were themselves exposed to physical danger, and in some instances the patients actually killed the lost object (so that guilt was *not* merely in fantasy); thus the untimeliness of the loved one's death seemed

to contribute nothing to the determination of the clinical pathology. Anderson's conclusions, however, coincide with Deutsch's and the present writer's ". . . certain neurotic responses are attempts to deal with and cure profound states of depression."

Stern, Williams and Prados[11] observe the following phenomena among "grief reactions in later life": an absence of grief, a preponderance of somatic illness, and a displaced irrational hostility toward living persons. While such reactions occasionally occur in younger persons subjected to untimely-death loss, the general characteristics described are more closely associated with advancing age in the mourner. It is to be noted, too, that these grief reactions were in response to the deaths of persons in later years, so that the deaths could not be considered untimely. In late middle age and particularly in old age, even when a death is sudden, there is a certain amount of preparation for it. A tentative explanation, advanced by the authors for these phenomena, is valid for the present paper: The assumption is that the symptoms are a "defense against dynamic forces that would be destructive to a weakened ego."

Lindemann[16] and Keeler[17] each write about grief reactions without discussing the dynamic importance of the untimeliness of the deaths in their cases. Lindemann's case material is largely based on reactions to accidental deaths in a night club fire. Many of his patients were participants in the tragic event; hence their reactions (like those described by Anderson) may have been parts of traumatic neuroses. Curiously, Lindemann cannot correlate the reactions to previous psychological status. Keeler studied 11 children's reactions to the death of a parent and notes in order of frequency: depression, fantasies of reunion, identification, delinquent behavior, suicidal attempts, and anxiety. He makes no attempt to explain the reactions, other than to liken them to normal and pathological mourning states. The writer has observed catatonic-like grief reactions with recovery in adolescents who have lost young parents. The young children in Case 5 of the present paper reacted with absence of grief. The mechanism of denial so frequently seen in depressions is also obtrusive in reactions to untimely death.

The similarity to traumatic neurosis of reactions to untimely death of a non-accidental kind is marked. The need to master the

psychological shock is common to both conditions. The mode of mastery determines the clinical picture, and is set by childhood patterning.*

That all the foregoing cases are women may be a coincidence (allowed by the small sampling; Peck's and Brill's patients were men), or may suggest that the incidence of these reactions—as in manic-depressive reactions—is higher in women than in men. (The part played by orality in determining depressive reactions has long been known.[1, 2, 3, 8] Spitz[18] has emphasized the role of the mother. More recently Benedek,[19] and Engel and Reichsman[20] have written of a "biological depressive constellation." Clinically Fabian and Donohue[21] have called attention to the frequency of depressions in the mothers of clinic patients. Further discussion of depression not related to untimely death would be beyond the scope of this paper.)

In addition to the foregoing observations, the writer has had occasion to observe more closely several normal reactions to untimely death: the cases of parents who reacted with the usual manifestations of grief to death of a child by illness or accident. In all these instances, the factors of untimeliness were not threatening to the mourners' egos. This ego-sparing may have reduced the impact sufficiently to permit normal grief reactions. Other factors contributing to the ego-strength of the bereaved also played a part. In past times, when child-death was common, parents were prepared through a state of almost constant expectation of death.

With reference to treatment, Freud[2] pointed out that in both mourning and melancholia, when the work of mourning is done, the patient automatically recovers. Deutsch[9] felt that there was only a temporary gain for the patient in displacement of affect. Lindemann[16] advised the conversion of abnormal grief into normal grief by sharing the patient's grief work. He was optimistic about recovery. For fear of precipitating psychosis, Anderson[10] warned against the use of physical or chemical means to produce quick abreaction. He felt that ECT, as in other types of reactive depression, was valueless. The writer's experience suggests that while reactions to untimely death should be treated as variants of grief

*Dr. H. I. Schneer has called to the writer's attention the moving picture, *Forbidden Games*, where children play a cemetery game in attempt at mastery.

reactions, they tend to be refractory, and patients are likely to be in therapy for a long time.

Varying conditions determine the ultimate prognosis (which was fairly good in the writer's cases). ECT in Case 5 prevented the formation of further somatic delusions, but had little effect on the manic agitation and none on the over-all clinical picture. Psychoanalysis, when feasible (Case 4), reveals the underlying structure of the neurosis and permits control of the affect experienced by the patient. (Kaufman[22] is optimistic about this procedure even in late life depressions.) Where suicide is a serious threat, hospitalization may be advisable. In treatment by psychotherapy (Cases 2, 3, 5), ambivalence in the transference should be watched for, and the patient should have adequate opportunity for the expression of affect in appropriate doses.

Summary and Conclusions

From the literature and the writer's clinical material, the following conclusions are drawn:

1. Reactions to untimely death are variants of pathological grief and mourning, and may assume the form of obsessive-compulsive neurosis, anxiety state, hysteria, manic-depressive psychosis, or schizoid state. The clinical pictures are usually mixed and atypical in accordance with the varying basic etiological factors. A similarity to traumatic neurosis is present. A normal reaction may occur where ego-strength is sufficient.

2. Where the reaction to untimely death is a pathological one, the clinical picture is determined by the patient's childhood conditioning, and the extent to which the infantile neurosis has been mastered. If there is an actual threat to the patient's ego (for example, loss of provider or caretaker), the trauma is more keenly felt. However, as in other psychiatric conditions, the (internal) fantasy trauma is more important than the actual one.

3. Reactions to untimely death tend to follow the pattern of grief reactions which represent a defense against unbearable, painful affect, or a defense against serious internal ego-threat such as suicide.

4. Treatment should proceed slowly. Where drugs are employed, they should be sedative rather than abreacting. ECT is indicated only at the threat of, or in the presence of, psychosis. When the

underlying infantile neurosis can be worked through, as in psychoanalysis, the prognosis is good, but psychoanalysis may not necessarily be the treatment of choice. In psychotherapy, the dosage of affect should be controlled. While it is true that completion of the work of mourning offers the best hope for successful outcome, a permanent neurotic compromise may be the best result obtainable in some cases.

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PSYCHOTHERAPEUTIC EVOLUTION AND ITS IMPLICATIONS*

BY LAWRENCE C. KOLB, M. D.

At the present period in psychiatric history, when general interest is focused upon the clinical trials of an impressive series of pharmacologic agents, highly effective in alleviating the characteristic expressions of anxiety and mental aberration, a discussion of evolution in psychotherapy may well seem recondite. Nevertheless, both the theoretical and technical approaches to psychotherapy are undergoing important modifications.

The evolutionary moves in psychotherapy are a reflection of ongoing and continued dissatisfaction and criticism of current therapeutic procedures. They bring to the fore new information derived in the course of psychotherapy of adults, and valuable additions to knowledge pertaining to the developmental processes of children.

Since the field is a large one, it is intended here only to draw attention to certain emergent changes in the intensive psychoanalytically oriented therapy of several psychoses and a psychopathic state. For this purpose, the selection of the areas of discussion has been made on the basis of the writer's personal experience in training and practice. This experience has imprinted a philosophy, gained through success and failure in treatment of these conditions, of the need for detailed and minute study of the developmental processes which are associated with each of the several clinical syndromes. Only with information derived from the accurate scrutiny of the ongoing interaction between future sick pa-

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Delivered as the eighth annual lecture in memory of Richard H. Hutchings, M. D., at State University College of Medicine, Syracuse, N. Y., October 1, 1956. Dr. Hutchings, former editor of this QUARTERLY, former superintendent of Utica and St. Lawrence State hospitals and former president of the American Psychiatric Association, died in October 1947.

Since this issue of this journal is a memorial to Sigmund Freud, it is appropriate to quote from Dr. Kolb's introductiory remarks to this lecture: "Outstandingly among the state hospital leaders, . . . [Dr. Hutchings] supported A. A. Brill in his lonely task of introducing psychoanalytic concepts and techniques into this country. His support was more than personal; it was open and on a national scale. As we know, he actively pushed the organization of the Section of Psychoanalysis of the American Psychiatric Association, and was its second chairman. He did this at a time when the effort must have called for great courage, in a day when psychoanalytic concepts were suspect and easily derogated."

tients and family influences, may a rational therapy be established, suitable for application to the various symptom complexes.

As a point of observation from which one may follow change, the classical psychoanalytic technique offers a precise frame of reference. This technique is well known, and its theoretical structure is established. If its practice has not spread widely beyond large urban areas, it has been well described, discussed and even attempted beyond the circles of established psychoanalytic practice.

The history of the evolution of psychoanalytic psychotherapy is similar to that of many other new therapeutic processes for which great hope existed. The new procedure—which was originally developed and found to be effective in the treatment of certain individuals with neuroses—was widely and rapidly tried upon a multitude of ailments. As we have observed more recently with the somatic treatments, and can observe even now with the new pharmacological agents, there was initially great enthusiasm, numerous reports of excellent results and then a growing awareness and appreciation of failures and incomplete successes. Some turned away at this point, while others attempted to search for the explanations for the defects in the therapeutic process. These curious and persistent workers are responsible for the many new developments in the technique of psychotherapy as it exists today. The amoeboid gropings for new paths are continually evident in the literature. In the course of extensive experience, those techniques that are found satisfying will persist, while others are destined to be discarded.

Psychoanalytic therapy has a more ambitious aim than that of alleviation of symptoms. It aims to bring change in the personality structure of the patient so that at the termination of treatment he is not only symptom-free, but is capable of facing the internal as well as the environmental stresses that were conducive to the production and maintenance of the previous illness without again succumbing to the illness. If one accepts the additional tenet inherent in psychoanalytic concepts, that the series of interpersonal events occurring between parent and child are determinative to a large extent in the development of abnormal behavior disturbance, the reconstructed analytic patient should also have the potentiality of rearing children free of such illnesses. The analytic aims include, not only therapy for the patient but concepts for the pre-

vention of illness, both for the patient in the future and for the patient's offspring. While psychoanalysis stresses environmental processes as determinative in personality development, its originator and its outstanding proponents recognize and consider the potentialities of genetic predisposition to emotional disturbance.

Needless to say, the happy culmination of psychoanalytic treatment is infrequently attained. Nevertheless, we must continue to strive toward such aims, as we try successive therapeutic procedures, whether by psychotherapy or somatic treatment.

A critical assay of the therapeutic effectiveness of the various somatic therapies, including the newly introduced pharmacological agents, shows only that they provide alleviation of symptoms. This alleviation may be interpreted as secondary to a quantitative reduction in anxiety, not as an expression of qualitative modification of the personality structure. Quantitative changes, however, are the more easily attained, and even if not permanent, may be distributed to a wider range of disturbed persons. The successful prescription of one or the other method, or its judicious application to the illness of a single patient on the basis of well-defined tenets, represents a step in the evolution of future psychotherapy and a step that promises to help eradicate the dissension between those who advocate one form of therapy to the exclusion of the other.

As a means of providing a framework for the discussion of specific technical modifications (and at the risk of exposing the reader to ennui), a brief description of the psychoanalytic technique will be given—as it was developed originally for treatment of the neuroses. Then, in turn, this original model may be considered experimental, and it may be examined to determine the processes that appear to be basically sound, and the revisions in the technique that have been required in the face of specific tasks.

Briefly, the salient feature of the psychoanalytic technique is the systematic investigation of the transference relationship and the resistances of the patient, observed in treatment. As one knows, this means the systematic examination of the patient's perception of the physician and the patient's ongoing emotional responses to him. By describing this relationship and then associating to it in terms of experiences with others, the patient is frequently surprised to find how he has distorted the physician in terms of the

way he has learned to see others. From the repeated confrontation of such distortions of reality in a single individual in a usually neutral environment, the patient then may learn to discriminate more clearly the multifaceted personal contacts of his daily environment. Then he responds with appropriate emotions rather than with the ingrained repetitiveness laid down as the result of unfortunate past experiences. Resistance may be considered an expression of the ongoing interpersonal relationship with the therapist, a false perception of the therapist as some one who will respond unfavorably if the patient utters or acts out the unspeakable buried unconscious. For this therapeutic process to succeed, the patient has need to maintain an ongoing feeling of security in his relationship with the therapist, a relationship necessary for any successful psychotherapy. This security sustains him on emergence of anxiety and hostility, when these appear.

The processes of free association and dream analysis are techniques used to lead the patient to the experiences which determine his falsifications of current reality—the intimidating experiences which he has repressed and forgotten. All the other aspects of psychoanalytic practice such as the supine position, the formal relationship with the therapist, are subsidiary to the basic processes mentioned. They make it possible to maintain the analyst as a neutral figure. They bring to the fore the distorting perceptual processes of the patient and his limited and repetitive infantile and child-like behavior in society. Some would insist that interpretation is an essential part of the psychoanalytic technique, but there are many who have questioned its salient position in the psychoanalytic process. Certain recently-obtained clinical data at the Psychiatric Institute make the writer question the essential position of interpretation by the psychoanalyst to bring about the resolution of the transference distortions, the process which is the nucleus of successful treatment.

In the course of the treatment of the neurotic, the origin of each behavior trait, each repetitive thought process or somatic disturbance, is sought in this framework.

The ultimate aim of treatment carries with it eventual emancipation from the physician. Sometimes, this final aim is unfulfilled. The patient may appear to function well in society; yet the physician is aware that a persistent dependency exists, or in some in-

stances, that a distant but chronic paranoid relationship continues —although therapy is terminated. These are the end stages of many apparently successful and unsuccessful analytic ventures.

* * *

It is proposed now to review, in turn, some ideas about the establishment of the transference relationship in the schizophrenic and manic-depressive psychoses, its varying character, the potential personality attributes required of the therapist to manage successfully the several types of transference situation and the changes that have seemed necessary in the treatment of material provided by the patient in the form of associations and dreams as well as in the formal arrangements and aims of psychotherapy.

With the application of the psychoanalytic method to the treatment of the psychoses, it was soon evident that, as a therapy, the procedure failed to realize the hopes of its originators. Freud himself provided several pessimistic statements in regard to the treatment of schizophrenia by psychoanalysis. He originally referred to the illness as a narcissistic neurosis and suggested that therapy was impossible because of the inability of the patient to invest in the therapist and develop a transference relationship. Freud's explanation of the early failures on this ground has not been substantiated by subsequent workers; and it should be mentioned that he expressed the hope that others would find a way of working with such patients.

Intensive work with patients with this illness has elucidated over the years a technique of psychotherapy which may be utilized with success in many patients, to maintain them at a functioning level of social adjustment. This technique differs in many respects from that employed in the treatment of the neuroses, and its general precepts represent a true evolutionary process. Leading contributors to the original thinking in the field include Ferenczi, Federn, Sullivan and Fromm-Reichmann and their various associates.

The establishment of a working relationship with the patient is the cornerstone of the therapy of the schizophrenic. The relationship of the patient to the therapist is of a different quality than that seen in neuroses. It is exceedingly fragile and is subject to withdrawal on the basis of any suspicion, or indication, that there

is a limitation of interest on the part of the physician. Breaking through to obtain the trust of the severely suspicious, ill, nontrusting, withdrawn, highly sensitive and disturbed patient—who has not committed himself to treatment and who communicates in a private language or at a preverbal level—requires a degree of patience and tolerance that is beyond the capacities or interests of most psychiatrists. Furthermore, it requires that the therapist not be one who insists on conducting all exchanges in an office at a set hour. These patients develop sudden accretions of anxiety that demand answering phones, providing extra appointments, visiting homes and hospitals at times to get over rough spots. With the borderline, ambulatory, or so-called pseudoneurotic individual, the initial relationship is less difficult to obtain, though it remains tenuous for a long time.

An important aspect of the early stages of treatment of those schizophrenics who present a form of verbal contact that is incomprehensible to the physician is the necessity of working out the meaning of the patient's communications. In other words, a form of communication between the two must be established before treatment can proceed along more commonly understood lines.

Here one can discern a sharp diversion from the practices of analytically-oriented psychotherapy of the neuroses. The therapist does not attempt to have his schizophrenic patient associate, as if the patient were neurotic, to the verbalizations he is producing. Rather, he listens and tries to relate the verbalizations to the feeling tone of particular interpersonal events that are reported to have preceded the distorted communications or are observed to occur in close temporal relationship. Then, when particular communications are heard, the therapist may interpret the patient's feeling directly and make it possible for the patient to appreciate initially that he is understood and will not be hurt. Later the patient may be able to give up the symbolically distorted verbal communication for the more direct and customary modes of expression used by other people.

As an example, take a psychotherapeutic effort with a schizophrenic young woman who repeatedly ranted over Communism, and declared that it was infiltrating the government and that our leaders were not cognizant of it and were paying insufficient attention to it. At the same time, she emphasized how early she her-

self had recognized the Communistic threat, thereby intimating her superior powers of observation and interpretation. By careful observation of the sequence of events taking place in the therapeutic hours, it was noted that the outbreak of anti-Communistic ranting repeatedly occurred in relation to a series of associations in which she was reporting events in which she felt rejected, or when the psychiatrist's comments or activities suggested rejection. She was asked if she felt angry at such times and she admitted it. Subsequently, when the patient's vilification of Communism was observed, the therapist inquired what had taken place to arouse her ire. At such times she responded with a smile and immediately recounted some disturbing thought or event. It may be noticed that no effort was made to bring out an association to "Communism." It was assumed that her repetitive ranting in an angry way was related to some interpersonal action, either current or derived from the past, that aroused anger, and that the ranting provided a safe and symbolic display of the underlying emotions.

The same process has been evolved in resolving delusional thought in schizophrenic patients. Again, in contrast to the earlier psychotherapeutic efforts, the content of the delusion is ignored. Aside from the possible symbolic reference to interpersonal processes, the patient's remarks are listened to, as a means of identifying their temporal relation to the train of interpersonal events taking place in the therapy, and their relation to similar disturbing experiences with others in the past. When it is clear from observation that the content is repetitively produced in connection with a particular interaction and its associated affect between the patient and others, an appropriate effort at clarification and interpretation is made.

Another clinical example may illustrate this point. In this instance a brilliant, schizophrenic young woman presented as one of her original complaints, the somatic delusion that she had a body odor. No effort was made, nor any encouragement given, to have her attempt to associate to this symptom, to work out its origin, or to define its possible symbolic meaning. However, on the occasions when the patient reiterated this complaint, efforts were made, through questioning, to determine the actual circumstances in which she believed that she suffered a body odor. By "circumstances," was meant the time of the occurrence, the place, with

whom she was associated, and what the actions or words of other persons had been; and she was asked to describe these. It soon became clear that her somatic derogation occurred repetitively in situations in which she felt that someone toward whom she had some positive feelings made a move or gesture which she interpreted as rejection, and in which her loneliness was aroused. In examining each instance it was evident that the patient responded in an oversensitive way and explained the behavior of others on their dislike of her "body odor." It became clear that the establishment of this thought was related to the passing of flatus in company—a forbidden and unmentionable act in her own family environment—which she had never consciously had the opportunity to discuss and learn about in the family circle. This delusion has its good point, "If I did not have 'body odor,' they would like me."

At any rate, by defining the social setting of the expression of the delusion, it was possible to interpret on each recurrence the fact that the patient was speaking of another event in which she felt she was unwanted. The delusional expression disappeared, and she came to speak directly of her socially-aroused anxiety.

An important point in this therapeutic process is the continual alert appreciation by the psychiatrist of his own behavior in its totality and of its possible meanings to the patient. By necessity, the therapy is usually conducted with the schizophrenic patient facing the therapist. The patient has a continuing need to check his reaction through visualizing the gestures and moves of the therapist. The therapist must see himself as an active participant with his patient, and must be free to disclose his own feelings and the meanings of his actions in order to clarify the patient's frequent distortions of the situation.

Another departure from the customary analytic therapy of neuroses relates to the use of dream analysis. Most of those who attempt intensive treatment of the schizophrenic advise against the analysis of dreams. Work with dreams is considered unwise for several reasons. The most significant of these is that preoccupation with dream analysis perpetuates the patient's propensity for withdrawal into fantasy living. What such a patient needs, is to face continually the emotionally toned events of everyday living and to learn socially adaptive methods of accepting such events.

Also, it is considered that the primitive impulses of such patients are evident enough in their overt pathology for dream analysis to provide little additional information. It is true that Lidz has recently suggested the usefulness of dream analysis in some schizophrenic patients in the later stages of treatment. However, it would be unwise to disregard the long and hard-learned experience of many others, who have found that the use of dreams in treatment of the schizophrenic is more often harmful than helpful.

Much needed is a more thoroughgoing appreciation of the limitations of the psychotherapeutic process with the schizophrenic patient. Complete resolution of the schizophrenic process, fixed through ineradicable deprivations of early life, has not been obtained, even by those with the greatest experience and patience. Fromm-Reichmann tells the writer that aside from perhaps a single patient, she has not seen this aim attained. Nevertheless, many enthusiastic psychiatrists press their patients beyond their capacity in order to reach the ideal. In certain instances, incalculable harm is done by such therapists. It is distressing indeed to meet with schizophrenic patients who have been plunged into serious psychotic regressions when their therapists have severed the treatment bond in their own disillusionment. The willingness to recognize a continuing, supportive, though distant, therapeutic relationship should be assumed initially in accepting responsibility for treatment of those with a schizophrenic illness. This step—which is realistic in the context of the experience of our profession at this time—may provide in itself a significant forward move. By the continuing supportive role, it is the intent to signify only the willingness of the therapist to communicate with the patient periodically and when the patient indicates the need, after terminating the period of prolonged psychotherapeutic contact.

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While the interest in the psychotherapy of schizophrenia has been widespread for a number of years, comparable efforts have been made only recently to approach the treatment of manic-depression. There were many early failures in the psychoanalytic treatment of this symptom complex with trial of the classical technique. Obviously, such patients do not easily lend themselves, when

retarded or hyperactive, to the rigid routine of the customary therapeutic process. The new efforts make it evident, however, that modified analytically-oriented psychotherapy is possible for some and seems beneficial.

The older failures raised a number of questions which have provided impetus for the new efforts. For instance, the clinical observation that certain patients treated by the classical technique became more depressed raised the necessities for understanding this fact psychodynamically and for modifying the technical approach to avoid such a complication.

As a means of comprehending the transference situation with the depressive patient, comprehension of the current psychodynamic explanations for the initiation of depression and elation are worthy of consideration, particularly as the therapist comes to occupy a central role for the patient. It appears that the depressive spell is precipitated by an actual or fantasied loss of a love object. The patient feels the loss as endangering his security. A depressive attack may sometimes recur on exposure to obscure symbolizations of such an event. As an example, the onset of a depressive period took place for one patient while she was doing some abstract painting. Analysis of the meaning of the abstract lines of the painting related directly to cathedral windows, associated in her mind to a period of suffering during a trip abroad, made to abort the pain of a loss.

The patient over-reacts emotionally to his loss of a love object with both sadness and helplessness. He appears to be attempting to regain the lost person by two conflicting methods, coercive rage and submissive fear.

The shift from depression to elation takes place in association with vacillating processes of identification with the significant parental figures. During depression, the patient at one time identifies with the maternal figure in a submissive role. At the initiation of the period of elation, he denies the submissive, maternal identification and acts out an intense, acquisitive, sadistic drive, with fantasies of strength, in which he becomes emancipated, elated and over-aggressive toward the paternal figure with whom he is now identified. With the failure of his aggressiveness to accomplish the fantasied aim of revenge, the patient again has to renounce the paternal identification, and deny his aggressiveness,

and so he becomes depressed and helpless. It appears to be the general opinion that the original defect in the developmental process takes place in early life, because of a failure to realize the potentiality of simultaneous drives for love and hatred toward a single person, the Mother. It has been considered that the intensity of the rage responses, brought out when frustrated by separation or rejection, are such that they call forth guilt, caused by the presence of an overdeveloped super-ego, and also cause withdrawal, with fear of driving the loved one farther away. Some now doubt the relationship of guilty hostility to depression.

The initiation of psychotherapy, and for that matter, its continuing pursuit, is of an entirely different order with the cyclothymic than with the schizophrenic patient. While the transference relationship with the schizophrenic is one characterized by deep distrust and expectations of rejection, and is punctuated at times by explosions of hostility and accusations, the relationship with the depressed individual bears upon the therapist heavily because of the clinging dependency of the patient. The depressive patient demands that he be gratified. He attempts to extract or force the gratification from the therapist by his pleas for help, by exposure of his misery and by suggesting the therapist is responsible for leaving him in his unfortunate condition. He may offer promises or bribes as a means of attaining his dependency demands. Since these patients have learned well the ordinary techniques in social relations, their efforts are applied through means that are usually respected and are not easily put aside. Here, again, they differ from the schizophrenic, who is usually uneasy and inept in ordinary social relations.

Furthermore, the distortions of the therapist by the manic-depressive are in terms of a person open to the manipulations previously described or in terms of a moral authority, providing or denying approval, or in terms of a critical figure who fails to approve, but may indicate respect, with acceptable behavior. This stereotyped distortion of the therapist, combined with the thought-retardation of the patient and the restrictive, repetitive associations, devoid for the most part of evidence of sensitivity for emotional interaction with others, requires of the therapist an inordinate degree of patience and little in the line of personal satisfaction.

Between the high personal standards that such patients usually have for themselves, and their feelings of impotence and incapacity, the treatment may founder initially if the therapist urges productiveness. The patient's dilemma at this time appears to be of three sorts. He is unable to express the underlying sadness and rage that he feels, because of the guilt and shame which he attaches to the emotions of suffering. He expects that the expression of such feelings to the therapist will be met with lack of respect. Pressure by the therapist only arouses additional feelings of hatred and shame, because of the patient's incapacity to meet the standards which he feels are expected by the therapist.

The program of therapeutic interviews on a four- or five-hour schedule a week has been found inadvisable. The demands of such a schedule provide an implicit insistence that the patient be productive, probably exaggerating his shame and guilt. The general consensus now is that depressed patients introduced to the psychotherapeutic process are better seen one or two times a week. Furthermore, there should be no rigidity in requiring completion of the full therapeutic hour, if this seems undesirable. It may be mentioned that this variation of therapy protects the psychotherapist. The initial, if not the later, therapeutic sessions with depressed patients, are incredibly trying to the therapist, who must sit for long periods patiently doing little.

The writer has been personally impressed by the success of some psychiatric colleagues in the treatment of depressions. After some gross failures, applying the basic psychoanalytic technique in treatment of several patients with the manic-depressive syndrome, he found it useful to think of the differences between this technique and the techniques utilized by these colleagues. Without particular theoretical framework for treatment they utilized an approach which worked well in breaking through the depressive structure. Particularly conspicuous, was the nature of the interpersonal contact with the patient, which was markedly at variance with the passive role of a psychoanalytic therapist. Two obvious features of this contact are worth comment. The first is the continual verbalized reassurance that the patient will recover. The second has to do with a certain directness and openness in dealing with the patient's problems. It would seem that these pro-

cedures fit into our present concepts of the needs of the depressive patient.

The patient is seeking another, or substitute, love object. The process of calm reassurance fits this need symbolically. The patient also has a need to escape from the feelings of guilt caused by his repressed rage in the depression. Consequently, in the early stages of therapy, whenever the patient has reported events which seemed to be conducive to the production of rage and anger within himself, but has left unsaid the emotional connotation of such events, the writer has personally adopted the practice of immediately verbalizing such feelings, and stating their relationship to other persons involved in the patient's situation. In this way the patient is relieved of the burden of stating his rage or anger, and is not exposed to subsequent feelings of guilt for expressing these forbidden emotions. Yet he can identify the recognition of such feelings in another person whom he may respect, and, often he accepts such remarks with a sly pleasure. With the use of this elastic, nondemanding, and at the same time active, interpretive approach, it has been possible to abort depressions in several patients—and also to supervise the treatment of young psychiatrists who have done the same thing, even for some patients who have failed to respond to electric shock therapy.

Cohen and her collaborators also are of the impression that the classical passive role of the psychotherapist is not conducive to success in treatment of the manic-depressive. They express the defect in the role of the therapist in another way, stating that it implies to the patient that his needs will be met and that, thus, he is eventually frustrated again.

They also warn against active rejection of the patient's demands as reinforcing his concept of himself as bad. Also, Jacobson has pointed out that, in her experience, it is necessary for the therapist to show warm understanding, constant respect, and an interest in the daily activities, of such patients. She has advised that it is important to connect interpretations of the patient's transference fantasies with warnings of the future. The depressive patient's early good response is a spurious one; and, subsequent to it, the therapist may be confronted with the occurrence of a more severe depressive state or an elation. In the writer's experience, the therapist must be extremely alert to detect the recurrence of

depressive aspects of symptomatology. Such a recurrence must be immediately related to its precipitating cause, either in current disturbances in the environment as an actual loss, or in fantasy of loss. Immediate interpretation has aborted the attack for several of the writer's patients on a number of occasions. Here again, it is necessary that the therapist be active in providing interpretation and taking full responsibility for doing so. Jacobson is also convinced that it is best initially to have the depressed patients focus on the experience of recent loss rather than on the earlier events in their lives which determined or reinforced their depressive symptomology. With knowledge of the potential severity of the super-ego in these patients, it seems imperative that a cautious and slow psychotherapeutic introduction be used.

A consistently firm attitude is required to resist the inordinate demands of these patients. Experience seems consistent that, with relief of depression, they tend to wish to give up treatment. It is necessary to warn them of the dangers of too early detachment and that others have had recurrences or have been disturbed in other ways by premature withdrawal from treatment. Two patients followed by the writer over a five-year period both had hypomanic attacks at points when they went on vacation (feeling well) or when they fantasied or imagined breaking off treatment with the physician. Both tended to deny the significance of their attachment to the physician and to derogate the value of therapy.

In the case of each of these patients, full commitment to treatment and willingness to work on the underlying interpersonal experiences conducive to the illness came about following the presentation of a dream. In each instance, the patient described bizarre dream objects to which he was unable to associate. When asked to draw the objects, one of the patients produced a simple breast-like structure, assumed to represent a mushroom, and the other drew a tractor wheel with a hub. The significance of these perceptions was immediately apparent to the patients, who had just been denying their dependent longings, with pseudo-independent acting out as escape from treatment.

In the treatment of patients with cyclothymic illnesses, the usefulness of dream productions and associations cannot be discounted. These cyclothymic individuals live a restricted life of fantasy. Through the association of dreams, it has proved possible

to break through to deep-seated associations which gave a clearer understanding of their basic longings and conflicts. It is worth remarking that this active use of dreams is in contrast with the avoidance of such material, which has been noted in the psychotherapeutic treatment of the schizophrenic patient.

The effort to initiate psychotherapy for patients in hypomanic or manic states is even more complicated; but, with willingness to experiment, it has been successfully accomplished. Experience seems to show that with patients in these states—in which they identify with the covertly aggressive, sadistic and successful member of the family—the therapist must guard constantly against the provocation of rejecting a patient whose behavior seems designed for this purpose, as it is designed to embarrass the patient's significant object relations. In some instances, patients have become disturbed when therapeutic sessions were arranged daily, and, in others, the close contact with the physician has aggravated the hyperactivity, with relief occurring when the sessions were reduced. In most instances, direct firmness by the therapist has been salutary, particularly when dangerous acting-out is occurring. Conversion of manic or hypomanic symptoms to the depressive is agreed to be desirable. It has sometimes been effected by the therapist simply indicating his doubts as to the soundness of the patient's presumption that he has reason to behave as if he were successful or in control of the situation.

Active treatment with the new tranquilizing drugs provides an important evolutionary step in the therapy of patients with manic illness. Within the past two years—through the prescription of thorazine at the initiation of a cycle of manic activity—it has been possible to carry patients in continuing treatment who might otherwise have been hospitalized. The patients thus avoided the trauma of interruption of psychotherapy and admission to a hospital.

An important source of conflict for the manic-depressive patient, recently emphasized by Cohen and her associates, is that of strong hostility connected with envy which is repressed and avoided. They found in their series of patients, that the manic-depressive was often the best-endowed member of the family, and had been expected to provide the prestige for the group. This position placed great responsibility on him, yet exposed him to the

envy of his siblings, or even to envious competition with his parents. The future manic-depressive grew sensitive to envy and competition, and to counteract them, unconsciously developed the pattern of derogating himself, in order to conceal his full capacity. The writer's experience supports this opinion. The initial envious struggle appears to evolve in the Oedipal conflict.

The realistic aims of treatment of patients with the manic-depressive syndrome are to bring them to the point where they can consciously face periodic loneliness and separation without resort to submissive depression or revengeful overactivity. A real feat is the achieving of capacity to suffer a loss and be free of the pathological adaptation. Suggestive of such strength in the course of therapy might well be the patient's capacity to express his feelings of helplessness, sadness and rage directly and openly, and to expose his recognition of envy in himself and others.

* * *

Some years ago, Szurek and Johnson asserted that certain antisocial acts in children represented a defect in the development of the child's super-ego which exists because the parent sanctions the aberrant behavior unconsciously as a means of obtaining a vicarious pleasure. The sanction for the antisocial act may be expressed through innuendo in conversation with the child, errors of omission in correcting behavior, facial expressions, or even statements indicating that the form of antisocial behavior is preferable to some other.

In other words, the child is delinquent in a particular way because of the parents' unrecognized permissiveness for his particular form of delinquency. The permissiveness may often be granted unconsciously, even though the parent superficially interdicts it. For instance, in the case of a child's stealing, the parent may well have punished the child verbally and physically for his acts, yet, through actions or words of his own, has invited the child to perform the very stealing which he presumably disapproves. Szurek and Johnson's study made possible an extrapolation, from the field of child development, to understanding, and providing a rationale of, treatment in certain adult disorders.

Working with Johnson in a study of male homosexuals, the writer discovered that the eruption of overt homosexual activity

in four men occurred in each instance when the mother of the patient had interdicted the heterosexual interest of her son, but indicated willingness to have him contact men. The assumption was made that the therapist would be perceived in the transference as a seductive person, intent on maintaining contact with the patient and allowing outlet only in the homosexual sphere. The writer had the opportunity of observing the eruption of overt homosexual activity in a young man with latent homosexual ideas when, in the course of his treatment by a younger psychotherapist, the therapist made a permissive statement. The patient promptly had his first homosexual relationship. The point the writer wishes to make is that the passive-listening attitude of a psychotherapist may be pathogenic for antisocial acting out in certain instances, in the sense that it implicitly suggests approval of the antisocial or pathological behavior. It tends to maintain the destructive permissiveness of the earlier parental relationship. Again, permissive statements by a therapist who has inadequate understanding of the psychodynamic constellations leading to the eruption of antisocial behavior may invite disaster for the patient, by leading to the act, or by providing impetus to destructive acting-out.

For successful outcome in such cases, the therapist must intervene, must interpret the relationship of the patient to the therapist on the basis of relationship to the permissive parent and must indicate his unwillingness to accept responsibility for the continuation of the patient's delinquent behavior. The interpretation, to be effective, must be coupled with a willingness on the part of the therapist, to interrupt treatment if the patient is unable to make the test of discontinuing the pathological acting-out. The timing of such an intervention requires careful consideration. Certainly, a binding transference relationship must have been established, and the therapist must have developed fully the data which disclose the seductiveness and permissiveness of the parent.

Pertinent to the foregoing discussion is the recent portrayal by Anna Freud of her use of the technique of requesting homosexual patients to postpone their pathological satisfactions for increasing periods, in the interest of intensifying the treatment. In one instance, the patient recovered; and in the other the patient was entirely unable to tolerate the frustration. On neither occasion, was the request to defer homosexual activities made on the basis of the

psychodynamic formulation described for the writer's patients. It is possible that the complex of events, resulting in the recovery of the one patient who did defer acting out, was similar to that in the writer's patients, while another series of experiences determined the psychopathology in the second individual—who also recovered.

* * *

In describing the evolving psychotherapeutic approach to the several very difficult clinical syndromes, needless to say, it was necessary to oversimplify and neglect certain other therapeutic approaches and differing opinions. The aim has been to provide in a few clinical syndromes a view of psychiatry's growing awareness of useful variation in treatment techniques.

These brief, comparative, psychotherapeutic sketches of several psychoanalytically-determined approaches show that the initial transference relationship of the patient differs in the several conditions, that these differences have dictated both empiric and theoretic modifications of the technique of the psychotherapist and that they call for a discriminating judgment as to the use of the passive or active role, and of interpretations, dreams and associations.

The various types of patient-relationship increase the importance of determining the most adequate personality equipment of the psychiatrist or psychoanalyst for treatment of one or another of the syndromes. Still further, experiences with these different types make it evident that great responsibility rests on the psychiatrist (or on any other person who essays psychotherapy) as his intervention may prove either therapeutic or pathogenic—depending upon his proper understanding of the origin of the illness and on his selection of the tools he uses in treating the individual patient.

Again, from this comparative presentation, certain consistent propositions may be stated which pertain to the successful psychotherapy of any condition. They are: First, that a firm relationship of expectation be established between patient and physician; second, that the physician behave in such a manner that he neither explicitly nor implicitly repeats the attitudes of parents or parental surrogates which were conducive to the specific pathologic behavior; third, that the more clearly the therapist understands

the patient-parental interrelationship conducive to the psychopathology, the more probable it becomes that therapeutic success will follow.

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YUROK SHELL MONEY AND "PAINS": A FREUDIAN INTERPRETATION*

BY S. H. POSINSKY, Ph.D.

I

In the course of an intensive study of Yurok ritual (Posinsky, 1954), done primarily in terms of interaction theory, the writer was impressed by a remarkable if inverted similarity between the dentalium shells (the aboriginal money of the Yurok**) and the *telogetl* (the material but animate "pains" which are the primary cause or manifestation of illness among them). It was suggested that the *telogetl* or "pains"—which are finger-like in shape and covered with blood or slime when extracted and displayed by the shaman—are suspiciously similar in appearance to dentalia, except that the *telogetl* are maleficent rather than beneficent (ibid., pp. 161-165). Since Yurok values and morality are couched in financial terms, virtue and asceticism are expected to result inevitably in dentalia (wealth), whereas violations of morality and taboo produce the *telogetl* (that is, the maleficent dentalia) in the victim's body.

As the literature was insufficiently corroborative, the problem was kept in abeyance. However, a further consideration of the data confirms the original impression but necessitates a psychoanalytic level of interpretation and a somewhat different hypothesis: that the dentalia and *telogetl* are respectively the positive and negative aspects of an infantile introject, the breast and/or penis.

It has been established psychoanalytically that these parts of the body, or their psychic representations, undergo a symbolic equation—an *assimilation,* as Abraham (1924, p. 490) describes it—and that such symbolism is generally overdetermined.† It is also known that "other parts of the body, such as the finger, the foot, hair, fæces and buttocks, can be made to stand for those

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The writer is indebted to Warner Muensterberger and Joanna L. Zeckel for their comments on this paper. They are not, of course, responsible for any of the opinions expressed.

**A coastal and inland tribe of Indians of northwestern California.

†Cf. Money-Kyrle, 1939, pp. 86-91.

two organs" (ibid.), and that money frequently symbolizes the breast-penis equation. Thus, Onians (1951, pp. 124-125) notes that *caput* ("head"; our "capital") refers to money which produces "seeds" (interest); and he writes: "The custom of making money-boxes in the form of the female breast and other shapes of fruitfulness . . . seems to derive from the same thought" (ibid., p. 124, n.).

Unfortunately, the Yurok ethnographies are so deficient in primary data on anal functioning that the additional excremental quality of both the shell money and "pains" can be elucidated only by inference. At any rate, note has already been made of the physical resemblance of the shell money and "pains," in addition to the moral antithesis which exists between them in consciousness. After touching on several preliminary considerations, the writer will return to this problem and attempt to prove that the shell money and the material "pains" refer *unconsciously* to the breast-penis equation.

II

Yurok culture, which is patently anal, is marked by unusual legalistic tendencies and litigiousness (Kroeber, 1925, 1926); by a zealous concern with "face," honor, and prestige; and by a tendency to flare up at the slightest provocation, whether real or imagined. There appears, in fact, to be an alternation between meek passivity and almost "manic" aggressiveness. Daily life is ritualized to a marked degree; the sexes sleep apart (women and children in the "living house," post-adolescent males in the "sweat house"); there is a taboo on sexual intercourse for six months of each year, beginning with the autumn rains; and there is a great emphasis on reserve, self-control, and dignity. Nevertheless, the society is described as "tense" and "anarchistic" (Kroeber, 1925, pp. 4, 38).

In cultural terms, the anarchy rests on the simplicity of the subsistence and industrial techniques and on family self-sufficiency in a large sedentary population where little co-operation, exchange, or mutual interdependence is required. The great World Renewal rites and the Wealth Display dances, whatever their psychic determinants and consequences, involve feasts and the lending of dance regalia, and operate against familial and local self-

sufficiency. And the crassness of the Wealth Display dances does not disguise the fact that these contests, like the ball games between villages and the related gambling, serve to channel intense and disruptive rivalries into socially controlled oppositions which run their course outside of subsistence areas or war.

The unresolved struggle for prestige is carried on with wealth and property but also with numerous symbolic privileges. Thus, among the coastal Yurok, certain families possess and jealously guard the right to take the flippers when a sea lion is killed, and the right to take a specific number of cuts from a stranded whale. The flipper rights are transferrable, though not without anguish, and are the basis of a celebrated feud in which they were demanded, and finally ceded, as compensation for a murder (Spott and Kroeber, 1942, pp. 182-199). The division of a stranded whale is roughly proportional to status, and the rich are permitted to take double the amount available to the poor. The rich man's privilege in this matter is symbolized by the packstrap with which he drags home his portion of the whale. The rich and poor of the village take their allotted shares in prescribed order, and the remainder is left to visitors from communities which are not included in this division. Any violations of established procedure lead to brawls and killings. The prestige factors are so strong that a man who exceeds his rightful cut by a few inches may be killed for his presumptuousness.

The florescence of the World Renewal rites is certainly correlated with the absence of social or political controls outside the family. It may also be, though the data are lacking in time depth, that the more complex World Renewal rites—for example, the one at Kepel (Waterman and Kroeber, 1938)—are a response to the disruptions produced by the coming of the Americans to California.

In a deeper sense, as the writer has indicated elsewhere (Posinsky, n. d.), the inordinate Yurok passion for wealth, like the unrealistic fear of starvation, may be seen as a reaction to an infantile deprivation. Thus, pregnant women work hard, eat sparingly, and avoid prolonged sleep. Late in her pregnancy, the woman is required to rub her abdomen in the midafternoon in order to keep the fetus awake. (This is the period of greatest interaction within the family, and apparently also a period of great magical danger.)

During delivery, the mother must keep her mouth closed, or the fetus will not leave her body.* The newborn infant is not nursed for the first five or 10 days (or more), and it "is fed only a little water in which hazel or pine nuts have been rubbed, and which looks milky" (Kroeber, 1925, p. 45; cf. Erikson, 1943, p. 285). The explanation is that "if the child . . . were to take nourishment from its mother, the Yurok believe that its jaws would become affected and it would soon starve" (Kroeber, 1925, p. 45).

The infant is permitted to nurse in due time; but it does not partake of any other food until weaning, and it is not even permitted to "steal" a drink of water during its baths. Weaning is early by American Indian standards and must occur no later than the child's first birthday, though it should take place ideally at six or seven months. From birth until it is able to walk, the child is forcibly kept awake from midafternoon until sundown. Sleep during this period, the time of the main family meal, puts the child in danger of being bewitched, from which death is expected to follow.** Creeping, which lifts the dietary and sexual taboos imposed on new parents, is encouraged: The feet are left free in the cradle basket from the time of birth, and the infant's legs are massaged daily from the twentieth day on. Bowel training is instituted as soon as the child can walk, when it is led out of the house by an older sibling for bowel movements.†

III

It has been hypothesized in the foregoing that the dentalium money represents the positive aspect of an infantile introject—"good body contents," in Kleinian terms—and that the symbolism, deriving from the various levels of psychosexual development, is overdetermined. It has been noted also that, in consciousness at least, the Yurok shell money is antithetical to food and genitality. Thus, the Yurok eat moderately and conserve their genital resources in order to acquire or retain dentalia; this is a conscious formula for wealth which they practise in their daily behavior and

*The psychic identity of mouth and vagina is here revealed—and perhaps infantile fantasies about oral impregnation. At any rate, one possible exit (entrance?) is closed off to avoid a dilemma for the fetus.

**The correlation of mealtime (eating) and witchcraft indicates deep-seated oral aggressions and talion anxiety, and will become progressively clearer during the discussion which follows.

†Other details about toilet training are lacking.

in magic. Unconsciously, however, there is a synonymity of dentalium-breast-feces-penis, with anal retentivity the dominant theme.

Kroeber (1948, p. 618) has noted that the anal-type description fits the Yurok strikingly; and Róheim (1950) has summarized their anality in the following formula: "Hold everything inside, extend *sphincter morality* (Ferenczi) both backward to the oral and forward to the genital zone. The most stingy of all human beings—that is what I would call the Yurok" (p. 272; his italics).*

However, just as there is a danger of emptiness, there is a comparable danger of fullness—of holding everything inside (cf. Burlingham, 1955); and it is this dilemma which places the Yurok in a tenuous psychic balance. Róheim (1950) has pointed out certain aspects of this dilemma in his interpretation of the Yurok passion for wealth:

> The men have to become *rich,* i. e., mothers full of *"good body contents"* (food, feces, embryo, etc.), because they have been frustrated by their own mothers. Hence their oral aggression is directed against the mother's body, and what follows is the corresponding talio anxiety. They will be "scooped out," empty—i. e., poor. To be rich means to be full of *good body contents,* i. e. food stabilized into a fecal symbol. It also means to be magically and ambivalently identical, both with a *full,* i. e. gratifying, mother and with a bad, withholding mother (p. 275; his italics).

But Róheim's interpretation is incomplete because he stresses only the alimentary quality of Yurok wealth; and in connection with the dentalia he writes: "The shells themselves are probably female symbols" (ibid.). On a pre-Oedipal level the shell money is certainly equivalent to a positive introject, or "good body contents"; but it also develops a phallic component which reinforces the previous ones. (Similarly, as will be noted presently, the *telogetl* or "pains" constitute a negative introject or "bad body contents," with components that also mark the several phases of psychosexuality.)

The most powerful evidence about the phallic aspect of the dentalia comes from the stringent taboo on sexual intercourse within the "living house":

> The Yurok hold a strong conviction that dentalium money and the con-

*Erikson (1943), though he describes the Yurok as miserly, compulsive, suspicious, and so on, does not accept the concept of Yurok anality. A detailed consideration of his objections would lead too far afield. The writer has dealt with this problem in another paper (Posinsky, n. d.).

gress of the sexes stand in a relation of inherent antithesis. This is the reason given for the summer mating season: the shells would leave the house in which conjugal desires were satisfied, and it is too cold and rainy to sleep outdoors in winter. To preserve his money, in other words to prevent his becoming a spendthrift, a man bathes after contact with his wife, and is careful not to depart from the natural positions. Strangely enough, the Yurok have a saying that a man who can exercise his virility 10 times in one night will become extraordinarily wealthy; but there are not wanting those who consider this ideal unattainable by modern human beings (Kroeber, 1925, p. 41).

It may also be that intercourse away from the house is necessary in order to avoid children's witnessing a primal scene.* That is, the parents project their own infantile aggressiveness and sexual curiosity onto their young children, who in turn become the potential cannibals, voyeurs, and castrators. Interestingly enough, this compulsive avoidance, with its Old Testament rigor, is negated by the unrestrained license and aggressive exhibitionism which prevail during the summer—when food is most plentiful and conscious and unconscious enemies may be taunted with wealth and bountifully appeased with food. Thus, conscious rivals (and mere onlookers) are taunted and feted in the World Renewal rites; so, unconsciously, are the basic enemies, originally the parents, but also—by displacement and projection—the children.

At any rate, the basic taboo, the postulated flight of the shell money (which here refers to semen or penis), and the poverty which will result inevitably from intercourse in the living house and from a failure to bathe after coitus—these are patent rationalizations which spring from a deep-seated castration anxiety. And, as always, this castration anxiety is overdetermined. It is intensified during the Oedipal phase, but it is very important in the pre-Oedipal period and may be traced to the original oral trauma. Thus, to be poor means originally to be hungry or empty, but it also comes to mean *to be without a penis.*

There is, again, a danger in emptiness (starvation, lack of love, poverty, castration, death), *and* a fear of fullness. The danger of fullness grows not only from the projection of oral aggressions

*Similarly, children are not permitted to talk about sex while their parents are alive. To do so is a double offense involving "swearing" and ridicule (cf. Erikson, 1943, pp. 270, 288).

onto the mother (and father) and the consequent fear of retaliation, but also from the ambivalence involved in fullness— which means both good and bad body contents. Thus, the fear of emptiness makes the Yurok greedy and retentive, while the fear of fullness makes them moderate eaters who must keep the alimentary passage open: Death is ascribed to a *visceral constriction*, and the material but animate "pains" are both *obstructions* and *parasites*.

As indicated, ambivalence toward the body contents (and toward the internalized parental images) is laid down during the oral-anal period and is reinforced by the negative and positive aspects of the Oedipus complex. There is thus an identification with, and an ambivalence toward, both sexes, with a marked tendency of males toward the avoidance of women; this is accompanied by a homosexual, but aim-inhibited, turning and submission to men in the exclusively masculine (and ascetic) atmosphere of the sweat house. In fact, the paucity of evidence about conflicts between fathers and sons would appear to indicate that the basic anxiety is pre-Oedipal and grows from the wish to rob the mother's body of its contents with this wish being projected onto others and being reinforced by the castration fears (and wishes) of the Oedipal phase (cf. Jacobson, 1953; Loewald, 1951; Muensterberger, 1955, pp. 14-17).

The resulting personality is remarkably *akin* to the configuration found in a compulsion neurosis. The libido has regressed, or is fixated, at the anal-sadistic stage; while excessive cleanliness, conscientiousness, and the like are reaction formations. (So is Yurok generosity with food, which results from an unconscious identification with the withholding mother.)

One can now understand the tenseness of this society; the heavy ritualization of daily life, which goes so far as to place a taboo on the use of personal names outside the immediate family; the emphasis on reserve and self-control, and the fluctuations between passivity and aggressiveness. Tempers flare up, feuds and lawsuits are instituted at the slightest pretext; but the encroachments of the white man were ignored, and the Yurok remained detached and apathetic (when they were not actively directing the white aggressor toward fellow-tribesmen and neighbors). They are given to tantrums and anal sadism when such behavior is safe, but they can be remarkably passive and submissive when force (or author-

ity) is demonstrated. Similarly, they aspire to Herculean sexuality and achieve it, partly in fantasy, partly in the carnival atmosphere of the summer festivals; but they are fixated in the *preparatory and defensive asceticism.*

As may be expected, anality overshadows whatever genital sexuality they achieve. Thus, to "do business" refers both to a bowel movement and sexual intercourse (Erikson, 1943, p. 285). This is notably similar to the "Protestant" or "Puritan" ethos and emphasis on "doing one's duty" in life, with "duty" becoming a childish word for excrement. It is significant that a number of "Protestant" or "capitalist" traits may be delineated in Yurok culture (Goldschmidt, 1951), and that Brierley (1951, pp. 177, 214) correlates the Protestant or Puritan tradition with the *maximum denigration of the sexual instinct.* Be that as it may, sex is a dangerous and dirty business for the Yurok; but it is also aggressive and manly, both in a phallic and anal sense. Nevertheless, the anal contradictions cannot be resolved; for genital sexuality may eliminate the dangers of fullness, but it also results in emptiness (starvation, poverty, castration).

The alimentary dilemma (fullness vs. emptiness) explains many of the paradoxes of Yurok behavior: the fear of starvation in the midst of plenty; the tendency to eat moderately and to accumulate large amounts of food; the generosity with food and the miserliness with everything else; the anti-genital attitudes and the periodic license; and the accumulation, by borrowing and hoarding, of large amounts of wealth which have no realistic value in terms of adaptation and survival, and are never consumed, but which are aggressively exhibited and thus arouse great fears of envy, damage, and robbery.

The conscious antithesis between wealth, on the one hand, and food and genitality, on the other, like the unconscious need to avoid fullness and emptiness, is further revealed by the need to abstain completely from food and water when practising wealth magic, and by the general emphasis on slow and modest eating which must be accompanied by thoughts of wealth:

> The father teaches the boys and the mother the girls how to eat. They are told to take a little food with their spoon, to put it into their mouth slowly, to put the spoon back into the eating basket, and to chew slowly and thoroughly, meanwhile thinking always of becoming rich. Then the

food is to be swallowed and the child may again reach, without haste, for the spoon. Nobody is supposed to talk during the meal, so that everybody can concentrate on thoughts of wealth. While there is still food in one's basket or in one's mouth, one does not ask for more. If a child eats too fast, the father or the mother silently takes his basket away from him and the child is supposed to rise silently and leave the house (Erikson, 1943, p. 286).

These and other restraints generate additional aggression against the mother (and/or father), as Róheim (1950, p. 273) has noted, but they also require a stronger repression of the basic infantile hatred. Since the "pains" result primarily from a violation of food taboos (but also from incestuous fantasies), the inverse relationship between dentalia and "pains" grows clearer: Slow, modest, *unaggressive* eating appeases the withholding mother and results in the acquisition of her favors (wealth, good body contents), while aggressive eating results in hunger, poverty, "pains" (bad body contents). Thus, once again, the ambivalence which is inherent in the infantile introjection and identification necessitates an avoidance both of fullness and emptiness.

The literature indicates considerable hostility between the sexes, with a powerful drive toward (and avoidance of) incest. Since the human race, according to Yurok mythology, was sired on a bitch, intercourse with a dog, here a kind of incest, is the ultimate offense and will result in the communal delegation of a villager to slay the offender. This is perhaps the only occasion when the village functions as a political unit, and no indemnities are payable for such a killing; otherwise, self-help and retaliation are in effect.

The rigid dichotomy of the sexes, and the underlying hostility and castration anxiety which it reflects, begin at birth and are not permitted to lapse even in old age, as they do in many cultures. Thus, the tattooed chin of a woman keeps her separate and apart until death: "They say that an untattooed woman looks like a man when she grows old" (Kroeber, 1925, p. 78). Similarly, in Yurok mythological projections, the unnamed *woge* or prehuman ancestors—who occupy certain of the rocks along the river—cannot abide menstruating women or corpses. The result is that if there is a menstruating woman or a corpse in a boat, the woman or corpse must be removed from the boat at these points, carried around the rocks, and returned to the boat.

The power of this castration anxiety is indicated by its persistence. After the century of intensive acculturation which followed the inundation of northwestern California by the gold-seeking "Forty-Niners," most of Yurok culture has disappeared; but the menstrual taboos remain: "The understanding between the sexes in these matters goes so far (or can go so far) that one informant defined a 'nice girl' as one who always tells the boy beforehand when she is menstruating, thus saving him ritual trouble and subsequent loss of working time" (Erikson, 1943, p. 298).

Love, even for one's wife, is considered an aberration; and, like affection for a dog, it exhausts one's emotional reserves (or libidinal bank account, as is noted in certain neuroses) and results inexorably in weakness and poverty. A benevolent contempt is expressed toward women in general. Based on the infantile abandonment and colored by a fear of rejection and genital injury, this contempt is really a mixture of hostility and dependence. The genital aims are devoid of emotional commitment, even in marriage, and the rationalization is that women are little better than animals. (Was not the human race sired on a bitch? What can we expect from our women—are they not bought?) The social significance of the bride-price is thus reworked. The bride-price is not, of course, a commercial transaction but the means by which one kinship group relates itself to another and by which a man can appreciably raise his own prestige and the status of his future children. Nevertheless, the social meaning of the bride-price becomes overlaid with hostile sexual attitudes.

Thus, women are inferior (damaged, castrated), yet sexually seductive and promiscuous, like bitches. But sexuality leads to poverty, starvation, and castration, with the threats emanating both from the mother and father. The pronounced castration anxiety leads to anal-passive behavior (an identification with the mother and a self-castration), but this is as dangerous as the anal-aggressive behavior, which leads to retaliatory sadism.

Although the female psyche is inadequately explored in the literature on the Yurok, an identification with the hostile and withholding mother appears indicated by the unusual deprivations which are inflicted on the newborn infant. Significantly, the unconscious rejection of children is paralleled by a conscious wish for 20 *children* (10 boys, 10 girls). This theme enters symbolically into

the female puberty ceremony (Kroeber, 1925, p. 45), with 20 sticks being laid out on the river bank. The female wish for great fecundity appears to be another demonstration of the fact that *one is not empty* (or without a penis, since the woman also identifies with her father and her sons).

Since sexual intercourse must take place out of doors, lest the dentalia take offense and run away, only the most ardorous brave the cold rains which mark the six months beginning in the mid-autumn. Chapple and Coon (1942) explain it in this way:

> Among the Yurok of northern California, where there is an elaborate development of a system of ritual gifts within the political hierarchy, sexual intercourse is forbidden during the winter, which is the time of gift making (p. 478).

Unfortunately for this interpretation, there is no political hierarchy, and the incipient political organization is insignificant. Men lend each other dance regalia and other heirlooms for the competitive dances; but outright gifts are absolutely not reciprocal and are intended to ingratiate the giver with a desired ally.

The *de facto* taboo on sexual intercourse is ascribed by the Yurok to the bad winter weather and the need to retain dentalium money. A sedentary society with high standards of craftsmanship could have resolved these difficulties technologically, but the Yurok chose not to, preferring to inculcate anti-genital attitudes which are reinforced both by physical discomfort and by strivings for wealth. The simplest solution would be for them to keep the dentalia in the sweat house rather than the living house, especially since virtuous behavior connected with the sweat house is rewarded in dentalia. However, virtue really means asceticism; and the sweat house is exclusively masculine, while the dentalia have a female (alimentary) as well as a male (phallic) symbolism. It would also be very easy to erect a lean-to or other shelter where married couples could retreat; but this is not done.

It has been emphasized that the basic castration anxiety stems from the pre-Oedipal period and is the result of hostility toward the phallic mother or the undifferentiated mother and father, with the negative and positive Oedipus complex reinforcing this repressed helplessness, hostility, and guilt. On a reality level, the wealth of the mature males inculcates the same hostility and submissiveness in the young. As youths and men are socially and sex-

ually superior to women, so older men exact a considerable degree of deference from boys and young men. In view of the wealth and power which are lodged in the hands of the father (and the father's brothers), young men are slow in achieving social and sexual maturity. The older men may be hesitant to part with their wealth in obtaining brides for the younger men (this would be especially true where there are few if any marriageable daughters in the same family); and at the same time, the older men are themselves involved in Oedipal rivalries: the never-ending struggle for wealth and prestige, as in the Wealth Display dances.

Since kinship groupings above the extended family are absent, a young man must cling to his father and paternal uncles for protection and status, and he may easily be disinherited in favor of a younger brother, a cousin, a paternal nephew, or a life-long friend of his father. Wealth being obtained by inheritance, not by individual effort, men of all ages are urged to practise wealth magic. Young men in particular are expected to fast, abstain from sexual relationships, work hard, and observe all the taboos in order to acquire dentalia. Since the results may be expected only in old age, these various observances serve to limit the modest relationships between the men and their orally frustrating and castrating mothers (wives) and to inculcate submission to the fathers. The pursuit of wealth thus serves as a life-long instrument of social control, in addition to rationalizing the power and prestige of the rich families and of mature men in general.

The wealth magic is obviously oral in origin and involves a hallucinatory wish-fulfillment similar to that practised by a hungry infant. Although a controlled regression is involved, the megalomanic confusion between subject and object becomes clear, as does their ultimate identification:

> The persistence with which the Yurok desire wealth is extraordinary. They are firmly convinced that persistent thinking of money will bring it. Particularly is this believed to be true while one is engaged in any sweat-house occupation. As a man climbs the hill to gather sweat-house wood—always a meritorious practise, in the sense that it tends to bring about the fulfillment of wishes—he puts his mind on dentalia. He makes himself see them along the trail, or hanging from fir trees eating the leaves. When he sees a tree that is particularly full of these visioned dentalia, he climbs it to cut its branches just below the top. In the sweat house he looks until he sees more money shells, perhaps peering in at him through the door.

When he goes down to the river he stares into it, and at last may discern a shell as large as a salmon, with gills working like those of a fish. Young men were recommended to undergo these practises for 10 days at a time, meanwhile fasting and exerting themselves with the utmost vigor, and not allowing their minds to be diverted by communication with other people, particularly women. They would then become rich in old age (Kroeber, 1925, pp. 40-41).

Interestingly enough, this type of wealth magic is an important part of the training of shamans, who are predominantly women. Although the wealth magic of men aims at a hallucinatory incorporation of, and identification with, the good mother, the shamanistic data will presently indicate that the phallic component of the dentalia is equally strong. For the present, however, it may be noted that the various deprivations practised, both by men and by shamans, in their wealth magic aim at achieving a reward—dentalia, or the positive aspect of the breast and penis—in those very areas where the sacrifice and atonement are greatest (that is, by oral *and* genital asceticism). Thus, oral and genital needs are deferred so that they may be more adequately fulfilled at some future date. This childish aspiration, however, is never realized; it is a compromise dictated by the needs of a compulsive and ambivalent anality which seeks solely to resolve its own dilemmas (fullness and emptiness; sadism and masochism).

In view of the fact that the symbolism of the dentalia is reinforced at each level of psychosexuality and is consequently overdetermined, it is easy to adduce considerable supplementary evidence about the basic breast-penis equation. Thus, the shell money is anthropomorphized, like salmon and deer; and it is deified in the person of Pelintsiek ("Great Dentalium"), a culture hero who sometimes assumes certain of the broadly institutory functions which are ordinarily ascribed to the two dominant *woge,* Wohpekumeu and Pulelukwerek (Kroeber, 1925, p. 74). Sometimes the dentalia appear in a female role, when, at the transition from *woge* times to the beginning of the human world, the personalized shells enter boats, and sing and dance as they leave their upriver home and go downriver into the ocean *and away from Yurok territory,* with the larger and more valuable shells going the greatest distance (Spott and Kroeber, 1942, pp. 249-250). This myth "rates the shells in value, tells where they are to be found, and explains

why the precious ones now occur only at a distance" (ibid., p. 250); but it also reveals the loss of the love object at the *beginning of the world* (at birth). The breastlike character of the dentalia, together with the nostalgic yearning for them, is also revealed when "they speak in their traditions of the shells living at the downstream and upstream ends of the world, where strange but enviable peoples live who suck the flesh of the univalves" (Kroeber, 1925, p. 23).

At the same time, oral aggression—rapid eating, gluttony, cunnilinctus—will drive away the dentalia (and also the salmon and other personified foodstuffs); while the dentalia, like the salmon and deer, also suffer from castration fears and will not enter or remain in a house where there is a menstruating woman. The phallic aspect of the dentalia, which is so strikingly revealed in the taboo on intercourse within the living house, is also clarified by the sacred narratives. Thus, there is an important culture-hero of primordial times, Wohpekumeu ("Widower across the Ocean"), who constantly pursued women, often unsuccessfully, and "according as his wooings resulted, he made or marred good fishing places" (Kroeber, 1925, p. 73). (This inverts the conscious antithesis between sex and wealth, and between sex and food.) It was he who sired the human race on a female dog, committed incest with his daughter (Spott and Kroeber, 1942, pp. 233-235), and was involved in castrations and countercastrations which are reminiscent of Zeus' behavior:

> Eager for feminine conquest, he attempted to deny or evade his son Kapuloyo, and finally, in order to marry the young man's wife, abandoned him on a high tree and blinded his grandson Kewomer. Kapuloyo escaped, gathered to himself all the dentalia in the world, and departed downstream; but near the mouth of the river, Wohpekumeu overtook him and recovered enough money to restock the supply for men (Kroeber, 1925, p. 73).

It was Wohpekumeu who instituted birth, stole acorns from the sky, and liberated the salmon for the future use of mankind. However, despite his positive achievements, his erotic strivings were so intense that he was finally abducted (castrated) by the Skate Woman. The meaning of his punishment is confirmed when we learn that "a skatefish looks like woman's inside" (Erikson, 1943, p. 272).

The converse of the instinctual Wohpekumeu is seen in another creative *woge,* Pulekukwerek ("Downstream Sharp")—"so named from the horns on which he sat" (Kroeber, 1925, p. 74). These gluteal horns appear to represent an anally displaced penis. At any rate, Pulekukwerek, who is a personified super-ego, is "a grave, unconquerable character, who smoked tobacco but never ate, passed women by for the sweat house, and by strength and supernatural gifts destroyed monster after monster" (Kroeber, 1925, p. 74). The monsters being his own instincts, it becomes clear why he instituted (and/or drove women from) the sweat house. Unlike the unfortunate Wohpekumeu, Pulekukwerek "retired uncompelled to the far-away land of dentalia and everlasting dances. All that the Yurok have of respectful admiration in their mythology they lavish on Pulekukwerek" (Kroeber, 1925, p. 74).

We have noted frequently that money and wealth are important because they ward off starvation, poverty, and castration, and that money, on the various psychosexual levels, represents the internalized good object, whether breast, feces, embryo, or penis. The aggression and ambivalence which are involved in this incorporation and identification result in the concurrent internalization of the bad object, the "pains." The failure to achieve genital primacy or to synthesize the component instincts results in contradictions (fullness vs. emptiness; sadomasochism); and these will become clearer in a brief consideration of the World Renewal rites (Kroeber and Gifford, 1949).

The esoteric part of this ceremony is concerned with the magical replenishment of the salmon, acorns, and wild game—in a sense, with the bracing and renewing of the entire world. The secular and climactic portion of these rites is devoted to feasting and to the display of imperishable wealth. The dance sponsors, manifesting pride and apprehension, provide large amounts of food for the numerous visitors—much in the manner of the *esa-esa* ("free giver") of the Normanby Islands (cf. Róheim, 1950, pp. 151-243, 287; 1955, pp. 55-61). The Wealth Display dances, marking an aggressive display of inherited and borrowed wealth, frequently result in brawls. These outbursts of envy and pique are at times so intense as to disrupt the sacred rites, despite their cosmological importance and the mediations of the officiating priest.

Since the aggressive display of wealth takes place in the context

of feasting, it would seem that the exhibitionism is made possible only by the oral abundance and reassurance. In a sense, the exhibitors will not be eaten (or castrated) if they themselves eat modestly and stuff their guests with food. And it is only during this protracted ceremony, lasting five, 10, or more days, that the ordinarily ascetic Yurok permit themselves practical jokes, sexual license, and a brief carnival atmosphere. But even these festivities are not without their profound anxieties. Marking a victory of anal and phallic aggressiveness over genital drives, there is a great fear in the dance sponsors' minds that the dancers who are displaying their wealth will break or steal it. There is also a concern about the expenditure of food. As indicated, these various fears represent not only castration anxiety, but also the fear of being hungry and empty.

Thus, in one important ceremony which is frequently terminated by brawls, the following (and contradictory) components may be seen:

1. The generosity with food is an aspect of the infantile identification with the mother; that is, an identification with the good mother (or what the mother *should* be); but there is also an identification with the withholding, narcissistic, and bad mother, and a reaction formation against this miserliness. The generosity with food, like modest eating, wards off the dangers which emanate from the projection of oral aggressions.

2. There is a victory of anal retentivity (the accumulation of food and wealth for the dances), with anal sadism manifesting itself in the practical jokes.

3. There is an exhibitionistic and aggressive display of phallic wealth, with the sadism being especially manifested in the fights, sexual license, and so on, and in the retaliatory fears of robbery, damage, and castration.

To terminate the discussion of the shell money, there is an illuminating story from the Hupa* which clarifies the dangers of oral aggression and takes one back to the infantile situation:

The grandchild of the rich man of Medilding had its mouth constantly open. A shaman finally saw and proclaimed the cause. An ancestor of the rich man had asked to kiss a dead friend or relative good-by. He descended into the grave and, bending over the corpse's face, used his lips to draw out

*Neighbors of the Yurok.

from the nose the two dentalia that are inserted through the septum, concealing his booty in his mouth until the grave had been filled. According to the report, the rich man admitted that an ancestor of his had actually risked this deed; and the shaman declared that it was the same dentalia that now kept the child's jaws apart (Kroeber, 1925, p. 42).

The identity of wealth and mother, like the projection of oral aggression onto the newborn infant, clarifies the long delay in nursing after childbirth. Like the Hupa child who has been punished in the offending organ for his ancestor's crime, the infant which nurses immediately after birth will develop a malady of the jaw and will starve to death. Unfortunately, this traumatic withholding at the very start of life sets the psychic stage for all the events which follow. The early weaning and the premature pushing of the child to independence, to lift the sexual taboo from the parents, reinforce the original trauma and result in the fear of starvation (and later, of castration). The urgent need to keep the fetus and the infant awake reveals an unconscious death wish on the part of the mother; and it is conceivable, though not verified in the literature, that the mother refrains from nursing for the first five, 10 or more days (individual variations color the cultural pattern) because she herself feels emptied and depressed by the birth of the child—which in the unconscious would be an anal birth. It is also possible, in view of the identity of feces-baby-penis, that delivery is a castration, like the first menstrual period; and that, in identification with her own mother, it is a repetition of her own birth and the original separation from the mother (cf. Orens, 1955).

At any rate, the infantile trauma is evidenced, not only by the all-consuming interest in wealth (the desire to recover the lost object), but by the unusual degree of separation anxiety (which later flows into castration anxiety). There is, thus, an intense fixation to the place of one's birth, an aversion to travel unless this is urgently necessary, a reverence for the house and the river, and the tendency to give names to houses, trees, rocks—in fact, to cathect the entire environment with libido. The negative aspects of this separation anxiety are marked by minimal eating, a fear of starvation and poisoning, the rigid separation of the sexes, and the avoidance of cathecting people or pets with libido. The need to cling to the mother with one hand and to push her away with

the other is very reminiscent of the ambivalence manifested by a spoiled child.

As indicated, a resolution of this dilemma is sought in the inherently unstable compromise represented by anality. In fact, the numerous avoidances and the heavy ritualization of daily life are akin to a compulsion neurosis (Freud, 1907)—which itself reveals the instability of the anal compromise. At any rate, we can clarify the relevant aggression and ambivalence by examining the negative introjects, the "pains."

IV

As has already been noted, the *telogetl* or "pains" are *material and animate entities* which resemble the dentalia in appearance, being finger-shaped. But they have a negative meaning: They are the internalized "bad objects." It will also be recalled that the *telogetl* are the prime causes of disease and, when sucked out of the victim's body and exhibited by the shaman, are covered with blood or slime.

Like the dentalia, the "pains" are overdetermined and derive from the various phases of psychosexuality. However, there are a few illnesses which are not caused by "pains"; and these ailments require confession or a priestly formula rather than shamanistic sucking. In every case, the initial diagnosis is made by a shaman. If the somatic and psychic indications are unpromising, the shaman will not undertake the cure; and she can easily ascribe the ailment to factors other than "pains" and recommend priestly therapy—or retaliatory action if a sorcerer is causing the disease.

The "pains," in addition to being the primary cause of illness, are also the source of the shaman's power. "Pains" enter her body, sometimes through her own efforts, and make her sick; but they also give her the homeopathic power to detect and remove the "pains" of her patients. Although her own "pains" cause her lifelong distress, she has a partial mastery over them, by being able to vomit them up; and she is thus able to turn them to some personal and social good. In return, she is handsomely rewarded with dentalia; and, as will be noted presently, the joint acquisition of "pains" and dentalia is a significant theme in the training of a shaman.

Although there is no difference between the "pains" of the patient and the shaman, the latter often solicits her ailment and is

considered a deviant personality by Yurok standards. In view of the vomiting which precedes her initiation and marks her personality and her professional technique, she appears to have a large admixture of conversion hysteria. That is, she relies more on repression and displacement, than on regression to the anal level (cf. Freud, 1915, 1916; Nunberg, 1955). This is also indicated by the fact that certain of her "pains" have a marked phallic character, as do unusually potent "pains" in general (for example, those sent into a person's body by a sorcerer). At any rate, the shaman is able to suck out and exhibit the negative introjects which cause many illnesses, and she thus relieves her patients of hate, guilt, and anxiety. That certain purely somatic ailments may be involved does not alter the circumstance that every ailment is moral or supernatural in its causation and that the patient reacts to it with intense guilt. Whatever psychological insight the shaman may possess, and it appears to be considerable, she is primarily treating psychic and psychosomatic disturbances—most commonly, it would appear, the alimentary symptoms which result from hysterical displacements or from the inadequacy of the anal-sadistic compromise—and she is always free to prescribe non-shamanistic therapies for which she assumes no responsibility.

It has already been suggested that, on the pre-Oedipal level, the "pains" are visceral obstructions and parasites. Thus, the "pains" always come in pairs, with the plurality suggesting breasts *and* dentalia; and, like dentalia, they are of different sizes and are butt-ended.* They are "little things, not bigger than a finger and often less, and are described as of various shapes and colors, although usually longitudinal" (Spott and Kroeber, 1942, p. 156). The smaller pains are less potent, as the smaller dentalia are less valuable; and, as dentalia and other forms of wealth are envied and stolen, so the shamans are envious of each other and *steal* "pains" from someone else's patients or from a shamanistic novice (ibid., p. 165).

Seen only by shamans, the "pains" fly about in the air and lodge themselves in the bodies of human beings. The "pain" of one shaman resembles a redheaded woodpecker (an object of wealth), while another is black, but tipped with red at the larger end (ibid.,

*The sexuality of the paired "pains" is further clarified when they are described as husband and wife or mates.

pp. 219, ff.). In describing one of her "pains"—which she examined after vomiting it up—a shaman notes that *"it looked like a dentalium"* (ibid., p. 160; the present writer's italics).

Since illness always has a moral or supernatural causality, the "pains," the predominant causes (or *manifestations*) of sickness, have a similar etiology; they result from the violation of taboo (predominantly food and incest taboos) or from hostile sorcery. Occasionally, an illness is ascribed to a shaman: She has sent "pains" into someone because she is greedy for a fee. But this is a rare occurrence among the Yurok; and it is notable that the motive is greed rather than murderous aggression. In general, Yurok shamans are not able to cause disease and are more commonly believed to effect only partial cures (that is, leave one "pain" in the sick person) in order to claim further fees for second cures. Shamans may find themselves engaged in litigation if they refuse to diagnose ailments or if they fail to return the fees after unsuccessful treatments; but, being generally unable to cause disease, they are spared the retaliatory assaults (on their life and property) which make their profession a hazardous one among many other primitive groups. It is not clear, either in historical or distributional terms, why shamanism has become an exclusively female profession in northwestern California; and this is something of an anomaly by American Indian standards. But the shamans' general inability to cause disease appears to rest on the fact that they are withholding, like the Yurok mother, and that they are as greedy for "pains" as they are for dentalia.

Hostile sorcery, to which certain "pains" are ascribed, ranges from simple envy of a man's wealth (and the accompanying wish that he will sicken and disburse all of his dentalia to shamans) to a specialized and highly potent form of sorcery called *uma'a*. Before noting the obvious phallic component of the *uma'a* "pain," it is important to point out that black magic is generally practised by men, whereas curative magic is almost exclusively a female profession. On the other hand, men replenish the food supply (and the world) in the World Renewal ceremony, while women *create famines* and *starve the world* by means of "starvation medicine" (Kroeber, 1925, p. 4; Spott and Kroeber, 1942, pp. 202, ff.).

Uma'a is a term which describes both the sorcerer himself and the particularly malevolent "pain" which is involved. It is a type

of black magic which is remarkably similar to Central Australian "boning":

> Then there are people who have learned or bought a mysterious thing called *uma'a,* with which they destroy those whom they envy or hate. . . . Sometimes this thing is put on the end of a little arrow which is shot, at night from a distance, from a miniature bow at the house of the victim, one of whose inmates soon sickens. At times an *uma'a* can be seen at night, traveling on his nefarious errand. He may be carrying his charm concealed under his arm, but the thing is strong, breaks out, and is visible as sparks or a bluish light that shoots or rises and falls. If this enter a man, he is likely to sleep unto his death. Some shamans, however, can suck it out (Kroeber, 1925, p. 67).

As in the case of Central Australian "boning," the dreaded (and desired) homosexual assault by the *uma'a* results in a fatal sleep (regression, castration, death) (Róheim, 1945, pp. 120-134).

The Oedipal dream of a shamanistic novice reveals the phallic character of the *uma'a* sorcerer and of the flying "pains" in general:

> Thus, once while the others slept, I dreamed I saw an *uma'a* coming. One of his legs was straight, the other bent at the knee, and he walked on this knee as if it were his foot, and had only one eye. Then I shouted, dashed out, and ran down along the river. My male relatives pursued me and brought me back unconscious. Then I danced for three nights more. At this time I received my four largest pains. One of these is blue, one yellowish, another red, and the fourth white. Because I received these in dreaming about the *uma'a* they are the ones with which I cure sickness caused by the *uma'a* (Kroeber, 1925, p. 65).

Concerning the *uma'a* "pains," another shaman reports:

> When a doctor sucks out an *uma'a* pain she holds it between her hands, closes her eyes, chants . . . and then begins to sing. Then the pain flies upward, spirals in the air, and suddenly flies in a beeline to where it came from, leaving a trail of fire, by which the doctor can tell by whom it was sent. Usually she does not tell, for fear the *uma'a* will be sent back into herself (Spott and Kroeber, 1942, pp. 165-166).

The asymmetry of the *uma'a* is characteristic of phallic demons (cf. Money-Kyrle, 1939, p. 88). It is noteworthy, however, that the shaman herself is a socially recognized *phallic mother.*

As the phallic *uma'a* "pains" are stronger and more specialized than ordinary "pains," so one special class of shamans achieves the logical culmination in therapeutic specialization and is compe-

tent to treat psychoses: "There were shamans who in their initial dream ate a snake, carried it in their bodies, visible to other shamans, and sucked snakes from their patients; but the disease of which they cured was lunacy, not a bite" (Kroeber, 1925, p. 68). The shamans whose powers are derived from the internalization of a snake in a dream may be suspected of being not only more potent magically but also less pregenital than the other shamans; but the data are not adequate for a further exploration of this problem.

Interestingly enough, the peak of deviation is achieved by two male shamans (transvestites); they are not only unusually deviant, but they also clarify the basic breast-penis equation by repeatedly acting out and returning to the original infantile situation:

> There was a shaman at Murekw famous for his ability to handle hot stones and eat living rattlesnakes, and after his death one of his kinsmen continued the practise. Such arduous feats, however, are not characteristic of Yurok shamanism, in which jugglery is unimportant; and it is significant that both these individuals were men (Kroeber, 1925, p. 68).

Such acting out is not characteristic of Yurok shamans; but they do suck out and incorporate their patients' "pains" during treatment, and they incorporate "pains" or snakes in a dream—all of which are identical in motivation. Quite apart from his own infantile and homosexual needs, which are akin to the bisexual aspirations of the female shamans, it may perhaps be that the male shaman must also exaggerate and dramatize his therapeutic powers in order to compete more favorably with women in a consciously female profession. At any rate, the incestuous and infantile strivings which result in "pains," whether in the patient or the shaman, are becoming progressively clearer.

The dreams and fantasies about the *uma'a* demon reveal the maternal and paternal aspects of the "pains" in general and of the attacker, whether father, phallic mother, or the undifferentiated parents—for the *uma'a* sorcerer is both a phallic demon and a phallic mother. Sickness, then, like shamanistic potency, results from an incestuous assault by a phallic demon or from the cannibalistic incorporation of a parental figure (that is, a violation of the food taboos, which will be discussed presently). The shamans act out their infantile drives in a sucking therapy, while non-shamans attempts to negate all drives except anal retentivity.

The situation is, again, reminiscent of Central Australian sorcery, where a snake, a pointing bone, or a quartz crystal (the magic *nankara* stone, which is sometimes described as the excrement of a sky deity) is kept within the sorcerer's body but can be projected into someone else in order to kill or cure (cf. Róheim, 1934, p. 65). Interestingly enough, the shamanistic therapy of the Yurok, which is marked essentially by mouthing or sucking—that is, an assault* on the mother's breast or body (cf. Glauber, 1953; Róheim, 1955)—is also characterized by a phallic penetration and receptivity. Before attempting treatment, the shaman sings and dances, working herself into a trance-like clairvoyance which may even culminate in temporary unconsciousness; then the sucking therapy begins:

> The larger *telogetl* pains rest in the doctor's body enveloped in a "blanket" (*uka'a*) of something like slime (*sleyitl*). When the doctor's power comes on her, one of her pains rises in her gorge, and its *sleyitl* helps her to find the *telogetl* in the patient, as she moves her mouth over his body. She facilitates the egress of her pain by *putting three or four fingers into her throat* to retch it up. *It then passes from her mouth,* as she is "sucking" the patient, *into the latter's body,* and travels in this until it meets the pain which is causing the disease. The two slimy envelopes mingle and the doctor's pain *returns to the doctor,* drawing the other after it. Once the latter is safe in her body, she brings it up in the same manner as her own, and causes it to fly away to where it came from (Spott and Kroeber, 1942, p. 156; the present writer's italics).

This process, which is Oedipal in its positive and negative aspects, even if displaced to the oral zone, is akin to a conversion hysteria; and the shamans do appear to be hysterics. They express their genital (and incestuous) strivings primitively, whereas the more numerous compulsives in the society surrender their genital drives for a lower stage of sexual life (anal sadism).

Just as the shaman in the *uma'a* dream fled to the river (the source of salmon and life; the good mother) on awakening from her nightmare, in an attempt to protect herself against the aggressive father (or phallic mother) whom she nevertheless incorporated—so she incorporates the father and the mother in her

*A patient reports: "As she sucks, it is as if her chin were going through to your spine, but it doesn't hurt" (Erikson, 1943, p. 261).

sucking therapy and becomes a kind of phallic mother or socially accepted hermaphrodite. Her identification with the father in the dream and her ambivalent flight to the mother (the river) reveal the hostile and phallic aspect of her negative Oedipal strivings and the related homosexuality: the wish to penetrate the mother's body, in addition to submitting to the aggressive father. And she achieves both goals in her professional life, for she not only sucks out the "pains" but sends her own into the patient's body.

In reality terms, her cures bring her great wealth and power; and she is able to enjoy many masculine privileges which are strictly denied to ordinary women: She dances at certain rituals; she may enter the sweat house, but not when she is menstruating; she wears feathers in her hair rather than the basketry cap which is required of women; she exercises authority over her male kinsmen and co-residents; and she is permitted to use tobacco. The pipe, in fact, is the very symbol of her profession. It will also be seen presently that her initiation into shamanism is centered around the sweat house, that she sleeps and dances there, practises the wealth magic of the men, and so on.

Infantile cannibalism and the related food taboos further clarify the meaning of the "pains." Thus, the violation of a food taboo, in fact or in fantasy, will bring on a "pain." This circumstance makes it convenient for those young women who wish to become shamans, and they solicit "pains" by such a transgression. Other people receive the "pains" involuntarily and resist them. In either case, however, the "pains" result in illness; and the voluntary candidate for shamanism must undergo prolonged training before she is able to master her "pains."

The standardized "initiation dream" of the shaman-to-be begins with *the crying while gathering firewood* (an element of male ritual, the wealth magic) and reveals an *oral tension* and nostalgia for the *lost object* of infancy:

This is a native summary of a shaman's inception:

A woman on her way for firewood perhaps begins to think of the dead who formerly lived in her town, notes how grass-grown and dim the path is, clears it of brush and weeps in recollection. Not long after she dreams. A person says to her: "I pity you as you always cry when you gather

wood. You should become a shaman. Eat this!'' The woman, not knowing what it is, eats what is offered. She wakes and realizes that what she thought reality was a dream. The base of her sternum hurts; it is a pain growing in her (Kroeber, 1925, p. 64).

A more individualized "initiation dream" has been recorded:

I began with a dream. At that time I was already married at Sregon. In the dream I was on Bald Hills. There I met a Chilula man who fed me deer meat which was black with blood. I did not know the man, but he was a short-nosed person. I had this dream in autumn, after we had gathered acorns. In the morning I was ill. A doctor was called in to treat me and diagnosed my case. Then I went to the sweat house to dance for 10 nights (ibid., p. 65).

The "short-nosed person" is reminiscent of the phallic demon; and, being of the despised Chilula tribe, he is an "enemy." The climbing of the mountain, significantly called Bald Hills, makes this an incestuous dream; but there are also echoes of an oral situation, in which the phallic mother is offering bad meat to a trusting child.

The 10-day dance, called the *remohpo* or "doctor dance," requires a 10-day fast (atonement). During this period, the shaman-to-be repeatedly vomits up the "pain," displays it on a flat basket, and (in the native parlance) "drinks it again." This is followed by the *ukwerhkwer teilogitl,* the "pain-cooking dance." The culinary symbolism, like the fasting and nausea, reveals that an aggressively won and basically indigestible food is involved.

Not only does the candidate fast in atonement for her oral aggression against the breast-penis, with complementary impregnation and nausea, but she must also abstain from water (a mother symbol) for variable periods. Significantly, although the trainee is generally a woman, her increasing mastery of the "pain," by self-induced vomiting, is greatly weakened by the presence of a menstruating woman (cf. Spott and Kroeber, 1942, p. 161). This marks a return to the exaggerated castration anxiety of the society, which is shared by the women—not only from their own pregenital phases, but also from the onset of menstruation in adolescence, the time when the shamanistic call is most customary. The bloody or slimy "pains" ejected from the mouth are thus overdetermined; they have their pre-Oedipal roots, in addition to being a hysterical displacement of genital libido to the oral zone.

The previously mentioned incorporation of a snake in a dream, and in reality by the male (transvestite) shamans, requires no further discussion, except that it represents a dramatic and synoptic achievement of prohibited desires.

Since "pains" also result from a violation of the food taboos, this fact affords a further clarification of the nature of Yurok illness and of shamanistic vomiting. The basic taboo, despite its numerous ramifications, is simple: Salmon and venison cannot be eaten together and must not come into contact at any time. Supplementary but related taboos prohibit the washing of hands in running water after a meal of venison; to do so would drown the soul of the deer and prevent its return to the snares of the deserving hunter. Instead, and with Hebraic legalism, the hands are washed in a basket or a wooden bowl. Persons who are most cautious may even abstain from washing their hands after eating land game and merely wipe them dry. Similarly, the wooden platters on which venison is served are washed in a basket and never in a stream.

The mysterious or bad foods which are eaten unintentionally in dreams and result in "pains" are either foods which drip with blood or slime—or worse, as the dreamer realizes later, they are a mixture of land game and fish. The foods which drip with blood or slime represent the breast, which is being consumed aggressively; they also refer to oral impregnation (cf. the need to keep the mouth closed during childbirth, and the writer's theory that an anal birth is involved). The foods that must be kept apart refer again to oral sadism (cf. the Hebraic taboo against boiling the calf in the milk of its mother), to the incorporation of both parents by the child, and to the dreaded incorporation (by projection) of the child by the parents. The compulsive separation of the maternal foods of the water and the paternal foods of the land also indicates an early sexual rivalry with the parents, an identification with both, and a powerful desire to prevent parental intercourse.

Quite apart from the food taboos, it is again clear that the emphasis on slow and modest eating, with the mind directed to thoughts of wealth, refers to eating without aggression. Thus, unaggressive eating placates the mother (and/or father) and results in good body contents (dentalia). At the same time, the suppression of oral desires also indicates an unconscious repression of

Oedipal desires.* On the other hand, aggressive eating or the violation of food taboos, like incestuous fantasies or dreams, will result inevitably in bad body contents ("pains").

The ambivalence involved in incorporation, identification, and Oedipal rivalry is further clarified by the food taboos. Significantly, the would-be shaman who received blood-blackened venison from the short-nosed "enemy" on the Bald Hills alternated from venison to salmon in the same narrative:

> On the tenth day, while I was dancing, I obtained control of my first "pain." It came out of my mouth looking like a salmon liver, and as I held it in my hands blood dripped from it to the ground. This is what I had seen in my dream on Bald Hills. I then thought that it was merely venison. It was when I ate the venison that the pain entered my body (Kroeber, 1925, p. 65).

Another describes her great resistance to the shamanistic call, as well as her family's pressure on her:

> My mother says, "You be doctor." I say, "No." She say, "You much money, beautiful clothes; if not doctor, will have nothing." I again say, "No." She scold, she scold too rough; I go away from home, stay out at night, sleep with Nancy over in other village (Erikson, 1943, p. 262).

Although resistance is indicated, she has a dream shortly thereafter in which an old woman offers her some "bloody and nasty" substance in a basket:

> . . . she throw basket on me, it hit me on mouth; I swallow stuff, I no sense any more; I wake up with noise, Nancy wake me up. "You crazy," she says. I never tell I dreaming that night; not sleep again (ibid.).

Even though she does not communicate the dream to anyone and practises a defensive insomnia, violent nausea sets in, and she finally accepts the shamanistic call. Interestingly, this shaman, one of the most famous in the area, is disturbed in later life by "nasty dreams, dreams of snakes, which make her feel sick all over again" (ibid., p. 267); and she has to repeat her novitiate:

> I run around. Oh! *snake* all over; I hit them; all over my arm, I bite

*Although the developmental progression from orality to genitality is basic to the understanding of the relationship between oral and genital denial, the process is not exclusively unidirectional; rather, a circular causality or "feedback is also occurring, even if secondarily and retroactively. Thus, oral and anal problems are obviously carried into the phallic or Oedipal phase; but the phallic organization also influences the previous phases correctively.

them; I like crazy; I go to sweat house, I dance, everybody sing (ibid., p. 267).

There is no question that hysteria is involved, and that the second novitiate indicates a failure of repression.

The uncontrolled, and also the self-induced, vomiting of shamans is of further interest; it indicates the special skill of the shaman, with a professional technique derived from a hysterical symptom. But it is also significant because uncontrolled vomiting is abhorrent to the Yurok. Erikson (1943), on the basis of an ingenious hypothesis which minimizes Yurok anality, assumes that the aversion to vomiting is based on the "tube" configuration of the Yurok: that they have assimilated the geography of the area into their anatomical and physiological concepts, and that uncontrolled vomiting is dreaded because it reverses the normal vectors of the river and the salmon.

Such geographical determinism is simply too convenient. It ignores the infantile situation and ascribes an unwarranted causality to the physical environment. Insofar as there is an assimilation of geography to physiology, it is the result of a previous projection, with the river symbolizing the mother. The "tube" configuration, then, represents merely another type of animism, with the environment understood and described in visceral (that is, internal physiological and psychological) terms. In other words, there is a projection of internal experiences and affects onto the geographical environment.

The literature is not sufficiently corroborative, but it may be suspected that diarrhea, which does *not* reverse the vectors of the river and of food, is as dreaded as vomiting, with both representing the fear of emptiness—as is constipation, which represents the fear of fullness. (Cf. Erikson, 1943, p. 286, for the folktale in which the hungry bear overeats and then suffers alternately from constipation and diarrhea. It may also be noted parenthetically that diarrhea, like childbirth, may constitute a symbolic castration.)

Further, an environmental explanation of the Yurok psyche is too particularistic. How, on the basis of Erikson's *ad hoc* hypothesis, can one explain similar attitudes toward vomiting and the like in different, *non-riverine* environments? Conversely, how can one explain the general absence of Yurok attitudes (and a completely different character structure) in an environment which is

comparable to that of the Yurok, and even more intensively riverine, as among the peoples of the Northwest Coast (the Nootka, Kwakiutl, Haida, Tlingit, and so on—of whom the Yurok are only a culturally impoverished periphery)?

It would seem, rather, that uncontrolled vomiting, which is the predominant symptom in the candidates for shamanism, refers to a variety of stimuli and is overdetermined. It derives generically from an incorporative hostility toward the mother, and it results in the rejection via the mouth of bad body contents. It may also be reinforced, of course, by fantasies of oral castration and/or impregnation, or by fellatio and its negative (repulsion). This hysterical symptom is especially dreaded, it would seem, because of the delicate and unsuccessful compromise which the Yurok collectively achieve in their regression to anal sadism (compulsion neurosis), with its marked tendency toward self-control and self-deprivation, retentivity, and ritualization. Thus, among non-shamans, vomiting, "pains," or any other gastro-intestinal ailments represent a victory for ambivalence and the failure of the anal compromise. *Regression* having failed, the supplementary repressive powers of the shaman are introduced; whereas the shaman herself, who is primarily a hysteric, relies most heavily on the *repression* and *displacement* of her own genital strivings and regresses only briefly to orality during the time of therapy. The self-induced or controlled vomiting of the shaman places this dreaded hysterical process in the safe area of ritual, where it is used to exorcise the ambivalence and guilt of the patient.

In view of the synonymity of breast-feces-embryo-penis, it is possible that a supplementary coprophagous fantasy underlies the vomiting, whether in the sick person or in the shaman; but this is impossible to document because of the inadequacy of the literature. At any rate, the breast-penis meaning of the dentalia and the "pains" is further clarified in the training of the shamanistic novice. After partaking of a forbidden food or a forbidden mixture of foods in a dream, the young woman finds that a material and animate "pain" is growing within her. Whether solicited or not, the taboo-violating dream is productive of illness and requires therapy. In some cases, the young woman resists the shamanistic call and has the offending "pain" sucked out. Such a choice apparently is related to the personality of the young woman, and to the cir-

cumstances which obtain in her family. For example, there are some families in which the profession of shaman descends matrilineally, but not by inheritance. In addition to family pressures, certain deviant traits begin to differentiate the candidate: These ego deviations and weaknesses, together with inadequate object-relatedness, are summed up by excessive sleepiness, vomiting, and a variable degree of homosexuality. Further, since the arduous novitiate takes upward of two years, the call generally comes to adolescent girls, though they may marry later. If already married, a woman must be childless (itself a dreaded condition) at the time of the call.

At any rate, the preliminary rites test the candidate's qualifications, after which the prolonged novitiate is begun. The novice abstains from food and water for 10-day periods, she sleeps and dances in the sweat house, she undergoes training in self-induced vomiting, and she demonstrates her powers at various ceremonies.* Not only is she acquiring mastery over her "pains," but she is also acquiring more of them.

As indicated, the shamanistic pursuit of "pains" is similar to the wealth magic of the men; both are accompanied by abstentions from food and sexual intercourse, by crying aloud when gathering wood for the sweat house, and the like. In fact, the special affinity of "pains" and dentalia—that is, their unconscious similarity—is especially clarified by the wealth magic of the shamanistic trainee. Thus, one shaman reports of her novitiate:

> All that winter I went daily high up on the ridge to gather sweat-house wood and each night I spent in the sweat house. All this time I drank no water. Sometimes I walked along the river, put pebbles into my mouth and spat them out. Then I said to myself: "When I am a doctor I shall suck and the pains will come into my mouth as cool as these stones. I shall be paid for that." When day broke I would face the door of the sweat house and say: "A long dentalium is looking in at me." When I went up to gather wood, I kept saying: "The dentalium has gone before me; I see its tracks." When I had filled my basket with the wood, I said: "That large dentalium, the one I am carrying, is very heavy." When I swept the platform before the sweat house clean with a branch, I said: "I see dentalia. I see dentalia. I am sweeping them to both sides

*Certain optional, but expensive, "post-graduate" ceremonies result in an enhanced reputation and larger fees.

of me." So whatever I did I spoke of money constantly (Kroeber, 1925, p. 65).

Simultaneously, she is acquiring additional "pains" (cf. ibid., pp. 65-66).

As in the wealth magic of the men, one sees an oral tension and a crying for the breast. There is, again, a hallucinatory wish-fulfillment, with a confusion of subject and object, which also has its origins in the anal phase. In the wealth magic of the men, the result is limited to the putative acquisition of dentalia in old age; but the shamanistic novice is simultaneously seeking "pains" *and* dentalia. The twin themes of "pains" and dentalia are conspicuous in the novitiate, and the shaman invariably receives both of them, both in fantasy and in reality. In fact, every invitation to cure (to extract "pains") is preceded by a period of bargaining in which the payment, a string or two of dentalia, is exhibited to the reluctant shaman by the prospective patient's kinsmen.

The wealth magic of men and shamans is oral and incorporative. Like most Yurok magic, it "is of the most crudely direct kind, such as performing a simple action or saying the desired thing over and over again. The thousand and one occasions on which magic of this rather bare volitional type is employed reveal a tensity that usually seems brought on consciously. This emotional tautness, which contrasts glaringly with the slack passivity and apathetic sluggishness of the average California Indian, is manifest in other matters. Thus, restraint and self-control in manner and in relations with other men are constantly advocated and practised by the Yurok" (Kroeber, 1925, p. 4). Kroeber's descriptive summary, it may be noted, marks the transition from hunger and wish-fulfillment to anal sadism and tense ambivalence. Though self-induced and ritualized—that is, it is a controlled regression—the wealth magic constitutes a replaying of the infantile role, with oral cravings dominant but in the service of anal retentivity and phallic potency.

The flight to the mother (the river), the stimulation of the mouth and lips by the pebbles (cf. the eating of live snakes and the juggling of hot stones by the male shamans), the crying and the hallucination of dentalia—all these reveal the oral aspect of the dentalia; whereas the association of the dentalia with the masculine sweat house indicates the phallic quality of the shell money.

Nevertheless, the hallucinated oral gratification fails, both in infancy and in the wealth magic of the men; and it is only painfully realized in the wealth magic of shamans, for dentalia and "pains" are introjected at the same time. The result is that the painful stimulus, originally hunger, is projected onto the mother, who becomes hungry and orally aggressive in turn. This is probably the ontogenetic precursor of the widespread Yurok fears of persecution (cf. Nunberg, 1955). Thus, there is a deep-seated fear of poisoning—by a type of black magic called *ohpok,* in which harmless but despised items (the flesh of dogs, snakes, frogs, and so on) are secreted in a person's food (Kroeber, 1925, p. 67); by drinking river water or water from strange places; and by the incorporation of the parasitic "pains," which are charged with the projected aggressions of the nursing infant. The "starvation medicine" practised exclusively by women reveals the same fears, even if it is closer to historical reality than the paranoid projections which reinforce it.

The unusual florescence of wealth magic may be understood also in the light of the realistic fact that the staple foods, salmon and acorns, and secondarily deer, deliver themselves to the very feet of the consumer. This occurs only if a person lives correctly and observes all taboos and rituals, with failures of the food supply being ascribed to moral or supernatural transgressions. Reality, therefore, reinforces the volitional magic which derives from infancy, and it also strengthens the already hypertrophied superego.

It may also be noted that the persecutory mother appears to be indicated by the persistent "looking in" of the dentalia, again with a confusion between subject and object which is typical of hallucinations. The "looking in" of the dentalia suggests not only a hallucinated breast but also a primal scene; and, as in a dream, sexual curiosity is displaced from the subject to the object—in this case, to the dentalia. (Cf. the postulated flight of the dentalia if coitus takes place in the living house.) This displacement again suggests that the dentalia, like the "pains," are a part of the subject and are also a projection of the subject.

A supplementary insight may be obtained by noting that certain shamanistic novices gash themselves in their magic. This is completely voluntary and quite unusual, since the Yurok have a

general abhorrence of mutilation. It is absent from the wealth magic of the men, and is paralleled only in one type of masculine behavior. Thus, if a man has had intercourse with a menstruating woman, which is one of the most dangerous ritual offenses, he is required to gash himself during the purification ceremony (Erikson, 1943, p. 267). There is probably a similarity in the two types of behavior. The man wards off castration by sacrifice and atonement, that is, by means of a symbolic or displaced castration.* The shaman, on the other hand, sacrifices and atones in order to obtain (rather than retain) the male genitalia. In both cases, a defensive masochism wards off a retaliatory attack by those who have been sadistically used.

Further, in view of the intense asceticism which is characteristic of the wealth magic (the abstention from food and water), a pre-Oedipal situation is also revealed; and the aggression which was originally turned against the object, the depriving mother, is now masochistically inflicted on the subject. At the same time, the psychic and social bisexuality of the shaman, who is the phallic mother *par excellence,* clarifies the meaning of the overdetermined "pains" and dentalia. She obtains dentalia and "pains" by aggressive orality and by displacing her genital libido; while ordinary people regress to the anal stage and must give up "pains" and dentalia, oral and genital needs, fullness and emptiness, if they wish to be "healthy."

Being dysfunctionally worked out, the Oedipus complex of the Yurok results in an unusually prohibitive super-ego which threatens the ego constantly with starvation, poverty, or castration; hence the need to pile up good body contents, but at a price which only the deviant hysteric can pay (lifelong "pains" or bad body contents).**

V

In conclusion, the data appear to support the hypothesis that the shell money and "pains" are respectively the positive and negative aspects of an infantile introject, the breast and/or penis. Be-

*He, too, "menstruates."

**In view of the multiple criteria of normality, it is interesting that the shamans are deviant in terms of *social adaptation,* though their deviations are socially patterned; but they appear to be more *genital* (even if it is a displaced, hysterical genitality) than the more numerous anal-compulsives who are better adapted socially.

ing reinforced at the different stages of psychosexual development, the symbolism is overdetermined in each case. The general impression is that of a tense and heavily ritualized society marked by a collective "compulsion neurosis," with a variable admixture of "conversion hysteria" which is most pronounced among the shamans.*

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*The quotation marks are used because we are dealing with analogies, not homologies. Even if the psychic mechanisms are similar, their *functions* differ. The Yurok compulsive or hysteric is acting socially, even at the cost of genital primacy. In our culture such behavior is dysfunctional and anti-social.

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PRELIMINARY EVALUATION OF A NEW PHENOTHIAZINE DERIVATIVE—NP207

BY SIDNEY MALITZ, M.D., AND PAUL H. HOCH, M.D.

Goal

The purpose of this study was to determine the clinical value, side effects and dosage range of a new phenothiazine derivative (piperidinochlorphenothiazin) known as NP207 and to determine whether further more intensive, controlled research with this drug was indicated.

In addition, several patients also received a lysergic acid derivative (D-1-Brom-Lysergic Acid-Diethylamide) known as BOL-148 to determine whether a synergistic action resulted in combination with NP207.

Material

The case material consisted of 35 patients, 19 inpatients and 16 outpatients of the New York State Psychiatric Institute, New York City. Twenty-five of these patients were ordinary schizo-

Table 1. Diagnostic Groups and Results—NP207

Diagnosis	No. of Inpatients	No. of Outpatients	Improvement Rating 1	2	3	4	5
Schizophrenia, Pseudoneurotic Type ..	2	4	0	0	5	0	1
Schizophrenia, Simple	0	3	0	0	2	1	0
Schizophrenia, Catatonic	1	0	0	0	0	0	1
Schizophrenia, Paranoid	5	0	0	0	3	1	1
Schizophrenia, Mixed	11	2	0	0	6	2	5
Schizophrenia, Unclassified	0	2	0	1	0	1	0
Schizophrenia with Depression	0	1	0	0	1	0	0
Psychoneurosis, Mixed	0	2	0	0	0	1	1
Involutional Depression	0	2	0	0	2	0	0
Total	19	16	0	1	19	6	9

EXPLANATION OF IMPROVEMENT RATINGS

1. Cured (Patient symptom free and functioning well for at least five years).
2. Much improved (Symptom free and functioning well outside of the hospital).
3. Improved (Majority of symptoms subsided. Patient functioning at a better level).
4. Slight improvement (Patient slightly more manageable in the hospital. Primarily an administrative improvement).
5. Unimproved (No change from baseline).

phrenics; six more suffered from pseudoneurotic schizophrenia; two had involutional depressions with paranoid trends; and two were cases of mixed psychoneurosis. (See Table 1.) All these patients were characterized by varying degrees of anxiety and tension which interfered with their adequate functioning.

Method

The patients were carefully interviewed and evaluated before being put on the drug. The preliminary evaluation was recorded in each patient's chart as the *baseline evaluation.* All observations thereafter were equated to the baseline evaluation and gain or lack of improvement was determined from this. The rating scale of 1 to 5 was used in roughly quantifying the patient's progress. Patients were seen daily by the therapist, and detailed notes were made by the nursing staff over the 24-hour period. Blood chemistry studies, liver function tests, urinalysis, blood pressure, temperature and respiration records were done routinely.

The drug was given orally only in 25 to 150 mg. individual doses, and doses varied from 100 to 1,000 mg. daily. Hospitalized patients were usually started on 75 to 100 mg. the first day and raised 50 to 100 mg. daily until the maximum dosage was reached.

Table 2. Maximum Dosages and Duration of Treatment—NP207

Maximum Dosages Attained		Duration of Treatment			
Daily Dosage	No. of Patients	Days	No. of Patients	Days	No. of Patients
100	1	7	2	49	1
150	2	10	1	50	2
200	4	17	1	56	1
225	1	18	1	60	2
250	1	20	1	62	1
300	6	26	1	71	1
400	4	28	2	78	1
450	1	29	1	81	1
500	5	30	1	86	1
600	6	33	1	90	1
700	1	35	2	92	2
750	1	38	1	122	2
800	3	41	2	132	1
1,000	2	46	1	134	1
TOTAL PATIENTS—35					

(See Table 2.) They were then maintained on the maximum dosage for one to two weeks (unless extreme drowsiness required cutting the dosage earlier). The dosages were then reduced by 100 mg. daily to maintenance doses between 150 and 400 mg. daily.

Five patients received BOL 148 as well as NP207. With these patients NP207 was administered in the same manner as to the rest, with a maximum of 400 mg. daily but the BOL 148 was raised at the rate of only 1 mg. daily to a maximum of 5 mg.

Clinical Findings

Detailed results are listed in Tables 3 and 4. Slight drowsiness and a feeling of lessened tension were the first subjective experiences of the patients after receiving the drug. Reduction of tension appeared to be the major type of reaction produced by it.

However, relief from tension was not directly proportional to the degree of drowsiness, since some patients who experienced the greatest relief were only slightly drowsy, and a few others who were very drowsy experienced virtually no change. In some of the patients improvement was not noted until the dosage of the drug had been raised to very high levels (1,000 mg.) and then lowered again to between 200 and 400 mg. daily. Greater sociability, lessened irritability, diminished preoccupation with paranoid delusions and in one case, a dramatic subsidence of neurodermatitis were all seen with the drug and were probably secondary to the over-all reduction in tension and anxiety produced by the medication.

The five patients receiving NP207 and BOL 148 combined showed no greater synergistic action when these two drugs were given together than when NP207 was given alone. These five patients did not improve clinically at all and it may have been because they were a much sicker group to start with than the patients in the remainder of the series. Further investigation is required.

Side Effects

Side effects were minimal and were usually seen only in the higher dosage range—above 500 mg. daily. Drowsiness in varying degrees was the chief side effect but weakness, occasional epigastric distress, dizziness, rash, pruritis, slight nasal congestion, sore throat and conjunctivitis were also noted. (See Table 5.) It

Table 3. Individual Results With NP207

No.	Sex	Age	Days on Drug	Starting Dose mg.	Max. Dose mg.	Dx.	Imp. Rat.	Effects	Side Effects
1	F	23	132	75	800 (2)	S-M	3	Less irritability with the drug. The patient socialized better, was more relaxed.	Marked drowsiness and fatigue on higher doses.
2	F	37	134	75	800 (2)	S Par.	3	Less preoccupied with paranoid delusions, more relaxed.	Moderate drowsiness and fatigue on higher doses. There was a temperature elevation to 100.6° on the thirty-first and thirty-second days. Epigastric distress was noted.
3	F	20	86	100	600 (2)	S-M	3	Much less tense, more outgoing and better integrated on the drug. She was kept on a maintenance dose of 150 mg. daily for 67 days.	Marked drowsiness and fatigue on higher doses. "Sore throat." Increase in psychotic symptoms on higher doses of drug. Subsided again with lower doses (200 mg.).
4	F	22	38	75	600 (1)	S-M	3	Less paranoid and more outgoing on the drug.	Moderate drowsiness and fatigue on higher doses.
5	M	42	49	50	750 (4)	S Par.	4	Administrative improvement. Slightly more manageable and less overtly paranoid. The underlying paranoid psychotic structure was unchanged.	Marked drowsiness and fatigue on higher doses. Epigastric distress and dizziness noted.
6	M	32	7	200	300 (4)	S-M	5	No change. Treatment was discontinued when the patient left against advice.	None.

Table 3. Individual Results With NP207—(Continued)

No.	Sex	Age	Days on Drug	Starting Dose mg.	Max. Dose mg.	Dx.	Imp. Rat.	Effects	Side Effects
7	F	35	78	100	700 (1)	S Par.	3	This patient had been on thorazine treatment for 88 days without appreciable relief of anxiety and impulses towards self-mutilation. After 10 days of therapy with NP207 the patient became much more relaxed.	None.
8	F	27	41	200	200 (41)	PNS	3	The patient had been on thorazine therapy for 66 days with minimum benefit. She was more relaxed on NP207.	None.
9	M	18	71	150	1,000 (3)	PNS	3	This patient had considerable relief of tension and a dramatic subsidence of his neurodermatitis on the medication.	Nasal congestion of moderate degree was relieved by pyribenzamine, two tablets daily. Moderate drowsiness and fatigue on higher doses of PNS, subsided on lower doses. The patient developed diffuse salt and pepper pigmentation of both retinae while on the drug, more pronounced in the macular area.
10	M	38	81	200	1,000 (3)	S-M	4	Long standing well preserved schizophrenic with slight diminution of anxiety on the drug allowing better social integration. More comfortable on lower doses (500 mg.)	A slight nasal congestion was noted on higher doses. Moderate drowsiness and fatigue on higher doses subsided when the dose was cut below 500 mg.

Table 3. Individual Results With NP207—(Continued)

No.	Sex	Age	Days on Drug	Starting Dose mg.	Max. Dose mg.	Dx.	Imp. Rat.	Effects	Slight drowsiness.
11	M	33	35	75	500 (28)	S Par.	3	Patient's irritability and overtly suspicious behavor definitely diminished on the drug although underlying paranoid ideas were still present. Patient appeared to have better control and was not subject to outbursts of aggression as he had been previously. He continued to be seclusive.	Slight drowsiness.
12	F	37	60	100	500 (48)	S-M	3	Tension and anxiety relieved. She socialized better on the drug.	Slight drowsiness.
13	F	23	50	150	450 (47)	S-M	3	Tension and anxiety relieved. The patient socialized better, was less sarcastic.	Slight drowsiness.
14	M	52	17	50	150 (12)	PNS	3	Considerable diminution in somatic preoccupation and hypochondriacal concern. He went back to work after starting the drug and did not return for further treatment. (Outpatient.)	Slight drowsiness.
15	M	62	30	50	100 (27)	Invol. Par.	3	This patient had shown no response to thorazine, dexamyl and serpasil previously. A definite decrease in anxiety and tension was noted but there was little effect on depression. His suicidal preoccupation was much less severe. (Outpatient.)	None.
16	M	19	41	100	600 (12)	S-M	5	No change in patient's feeling of depression and apathy.	Drowsiness, fatigue, rash on 600 mg., subsiding spontaneously on lower doses.

Table 3. Individual Results With NP207—(Continued)

No.	Sex	Age	Days on Drug	Starting Dose mg.	Max. Dose mg.	Dx.	Imp. Rat.	Effects	Side Effects
17	F	37	92	200	200 (92)	PNS	3	Marked diminution in anxiety precipitated by threat of surgery. Anxiety had not responded to 100 mg. of thorazine daily for one month prior to NP207. (Outpatient.)	Drowsiness and fatigue.
18	F	41	35	100	150 (5)	S-M	4	Slight diminution in anxiety and phobic reaction. At times more panicky on the drug. This patient discontinued drug by herself. (Outpatient.)	Marked drowsiness.
19	F	51	46	100	400 (20)	Inv. Dep.	3	Decrease in anxiety, obsessive preoccupation and depression as long as patient on drug. Relapsed as soon as drug discontinued requiring ECT. (Outpatient.)	Dryness of the mouth. Slight drowsiness.
20	F	50	122	75	200 (50)	PNS	3	Drug effective in controlling feeling of panic and phobic reactions. Attempts to discontinue drug on three occasions resulted in exacerbation of symptoms. (Outpatient.)	Drowsiness. Rash.
21	F	48	92	50	300 (22)	S-M	3	Visual hallucinations, marked agitation and panic subsided with the drug. Panic returned but hallucinations did not recur on two occasions when drug was temporarily discontinued. (Outpatient.)	Rash with itching.
22	M	45	28	75	200 (14)	Anx. State	5	Attacks of nocturnal anxiety marked by palpitation tachycardia unaffected by drug. (Outpatient.)	Drowsiness.

Table 3. Individual Results With NP207—(Continued)

No.	Sex	Age	Days on Drug	Starting Dose mg.	Max. Dose mg.	Dx.	Imp. Rat.	Effects	Side Effects
23	F	55	62	100	800 (28)	S-Unclass.	4	Major problem one of intractable pain on a functional basis. Slight diminution in concern over pain but intensity of pain unaffected. (Outpatient.)	Drowsiness. Dizziness. Dry mouth.
24	F	31	56	75	400 (28)	S-simple	4	Slight diminution in depression and in tendency to withdraw while the patient was on drug. Anxiety and phobic symptoms responded better to the drug. The patient promptly relapsed after the drug was discontinued, into a severe depression requiring ECT. (Outpatient.)	Slight drowsiness. Dry mouth. Rash.
25	F	35	28	100	500 (20)	S-unclass.	2	Marked decrease in anxiety. Disappearance of depression. Return of reality control. (Outpatient.)	Marked drowsiness. Pruritis responded to benadryl. Dryness of mouth. (Severe grippe-like syndrome on thorazine did not recur with NP-207.)
26	F	32	90	100	400 (80)	S-Dep.	3	Reality control improved. Depression abated slightly. (Outpatient.)	Drowsiness. (Grippe-like syndrome on thorazine did not recur with NP207.)
27	F	32	60	100	300 (50)	Psycho. Neur-M	4	Some diminution in anxiety. Phobic and hypochondriacal patterns unchanged. (Outpatient.)	Marked drowsniess. (Jaundice with thorazine, not with NP207.)

Table 3. Individual Results With NP207—(Concluded)

No.	Sex	Age	Days on Drug	Starting Dose mg.	Max. Dose mg.	Dx.	Imp. Rat.	Effects	Side Effects
28	M	22	20	100	500 (14)	S-simple	3	Considerable decrease in anxiety and depression. Lack of reality control present before use of the drug, subsided when the patient was on drug. (Outpatient.)	Drowsiness. Pruritis. Heat sensitivity. (Last present also with thorazine.)
29	F	48	18	100	500 (12)	PNS	5	No change in marked anxiety, somatic delusions, phobias and compulsions. The patient discontinued drug herself. (Outpatient.)	Increasing difficulty with reality control. (Patient had jaundice with thorazine but not with NP207.)
30	F	55	50	75	300 (43)	S-simple	3	Decrease in anxiety, confusion and lack of reality control. Depression subsided completely. (Outpatient.)	None. (Grippe-like syndrome with thorazine did not recur with NP207.)

Figures in parentheses refer to total number of days the patient was maintained on the maximum dosage.

S. simple—Simple schizonphrenia
S-M—Schizophrenia, mixed
S. Par.—Schizophrenia, paranoid
PNS.—Pseudoneurotic schizophrenia
Involl. Par.—Involutional reaction, paranoid
Involl. Dep.—Involutional depression
S. Unclass.—Schizophrenia, unclassified
Psychoneur. M.—Psychoneurosis, mixed

Table 4. Individual Results With NP207 and BOL 148 Combined

No.	Sex	Age	Dx.	Days on Drug	Starting Dose	Max. Dosage NP207 mg.	Max. Dosage BOL148 mg.	Imp. Rat.	Effects	Side Effects
1	M	21	S Cat.	29	50	400 (11)	5.0	5	No clinical change in catatonic behavior.	None. (No appreciable drowsiness.)
2	F	30	S-M	33	75	300 (16)	4.5	5	No change in catatonic and hebephrenic behavior.	None. (No appreciable drowsiness.)
3	M	25	S-M	26	100	225 (8)	4.5	5	The patient continued to be preoccupied with his ears. Paranoid behavior was unchanged.	Temp. elevation to 100.2 2nd, 6th and 20th day on the drug. Epigastric distress. (Very slight drowsiness.)
4	F	50	S Par.	7	75	250 (2)	2.0	5	No appreciable effect on paranoid ideas or aggressive hostile behavior. The patient was on the drug for a very short time only.	None. (No drowsiness.)
5	F	27	S-M	10	200	300 (5)	4.0	5	No effect on hebephrenic, catatonic hyperactive behavior. (Deteriorated patient.) The patient was on thorazine, 200 mg., for 5 days following the NP207-BOL 148 with no improvement either.	None. (No drowsiness.)

Figures in parentheses refer to total number of days the patient was maintained on the maximum dosage.

S. simple—Simple schizophrenia
S-M—Schizophrenia, mixed
S. Par.—Schizophrenia, paranoid
PNS.—Pseudoneurotic schizophrenia
Invol. Par.—Involutional reaction, paranoid
Invol. Dep.—Involutional depression
S. Unclass..—Schizophrenia, unclassified
Psychoneur. M.—Psychoneurosis, mixed

Table 5. Side Effects—NP207

	Inpatients	Outpatient
Drowsiness		
Slight	4	2
Moderate	7	7
Marked	1	3
Weakness	8	1
Epigastric Distress	3	2
Rash	2	1
Pruritis	2	3
Dissociation Phenomena	1	1
Dizziness	1	1
Nasal Stuffiness	3	4
Retinal Pigmentation	1	0
Conjunctivitis	1	1
Jaundice	0	0
"Grippe Syndrome"	0	0
Parkinsonism	0	0
Hypotensive Phenomena	0	0
No Side Effects	7	2

has not been definitely established that the conjunctivitis was due to the NP207 but it must be kept in mind that cases of conjunctivitis have been reported with the use of chlorpromazine. The majority of cases developing epigastric distress received the non-enteric-coated 25 mg. tablet. The incidence of epigastric distress was much less in patients receiving the 50 mg. enteric-coated pill. The writers' experience with chlorpromazine in this respect has been similar and they feel that all phenothiazine derivatives should be enteric-coated.

Two patients developed intensification of their psychotic symptomatology on moderately high doses (500 to 600 mg.) of the drug which subsided immediately when the dose was cut to 200 mg. This same phenomenon has been noted with chlorpromazine and should be carefully watched for whenever phenothiazine derivatives are administered.

One patient, an 18-year-old white male, who received NP207 for 71 days (and who attained a level of 1,000 mg. daily on the fourteenth day, after which dosage was gradually reduced), complained of visual disturbances after 10 weeks on the drug. Ophthalmosopic examination revealed bilateral pigmentation of the retinae, most pronounced in the macular area. Up to the present

time there has been no change in the pigmentation, but the patient's vision has improved. The following report indicates dosage and eye findings in detail:

An 18-year-old, single, white schizophrenic male received NP207 according to the following regimen:

Date	Daily Dose	Date	Daily Dose
4/7/ 55	150 mg.	4/26/55	700 mg.
4/8/ 55	250	4/28/55	600
4/9/ 55	300	4/29/55	500
4/12/55	400	5/26/55	300
4/13/55	500	5/27/55	200
4/14/55	550	5/28/55	400
4/15/55	600	5/31/55	500
4/16/55	650	6/6/ 55	550
4/18/55	750	6/7/ 55	600
4/19/55	850	6/8/ 55	700
4/20/55	950	6/15/55	400
4/21/55	1000	6/16/55	150
4/24/55	900	6/17/55	Discontinued
4/25/55	800		

The patient was first seen in the eye clinic on June 15, 1955 for the following complaints: (1.) Difficulty seeing in low levels of illumination. (2.) Moving dark clouds intermittently present. (3.) "Vision very dull, as if looking through a film."

All of these symptoms were of two weeks duration. The patient had had a complete physical examination including eye ground evaluation at the time of his admission on February 2, 1955. This evaluation was entirely normal but the eye grounds were not examined through dilated pupils at that time.

Clinical examination of the patient's eyes on June 15 showed them to be completely normal except for the fundi. These were carefully examined by many people through dilated pupils on several occasions. The optic discs and vessels were entirely within normal limits. There was a salt and pepper type punctate pigmentation throughout both fundi but much more marked in the macular areas than elsewhere.

Several additional tests were carried out:

1. A manifest refraction indicated that he had myopia with astigmatism in both eyes and that his best vision in his right eye was 20/20 and in the left 20/25.

2. Visual fields were done on two occasions. The first on June 17, 1955, showed extremely constricted fields to the 2/1000 W test object—fields of two to three degrees in each eye. With a 5/1000 W test object

there was a large defect in the lower hemisphere of the right eye and in the lower nasal quadrant of the left eye. The second fields on June 20, with the 2/1000 W test object revealed fields of 20 to 25 degrees in both eyes with 5 to 10 degree cuts in the upper hemispheres. In the opinion of the perimetrist both fields were fairly reliable.

3. A Mazzini test was negative.

4. Electroretinograms were taken on June 18. The photopic ERG had all normal components and they were normal relative to each other. The entire ERG was diminished about 20 per cent which is of doubtful significance.

5. Dark adaptation curves were carried out on two occasions and they were similar. Both indicated only cone function, although on the second occasion, June 27, the threshold was 0.3 log units and there appeared to be a start of the chromatic shift.

The fundi were examined again on August 5, 1955 through undilated pupils. There appeared to be no change in the pigmentation according to the examiner who first saw the patient in the eye clinic on June 15, 1955. The patient's symptoms, however, had markedly improved.

Comparison of Chlorpromazine and NP207

Direct comparison of chlorpromazine and NP207 in the same patient was done in only eight cases, so that no accurate, point by point assessment can be made. Nevertheless, some observations can be reported.

One patient had been receiving chlorpromazine for 88 days without appreciable relief from anxiety and impulses toward self-mutilation. After 10 days on NP207, she became much more relaxed; and she continued her improvement while being maintained on the drug, until her discharge two months later. A second patient was on chlorpromazine therapy for 66 days with minimal benefit. After a week on NP207 she said that she felt more relaxed. She was continued on the drug until her discharge, and her improvement was maintained.

Six outpatients were started on NP207 therapy when it became necessary to discontinue their chlorpromazine therapy because of disturbing side effects such as jaundice and severe grippe-like symptoms. None of the complications continued or recurred with NP207. Clinical improvement, where present, was maintained in four of these six cases after the change.

Comparing the results of the writers' studies with the two drugs, there is no doubt that the incidence of side effects with chlorpromazine is much greater than with NP207. Troublesome side effects with chlorpromazine, such as jaundice, grippe-like symptoms, hypotensive phenomena and lactation, did not occur at all in the administration of NP207. Also, while changes in liver function tests were seen in chlorpromazine therapy, paralleling the development of gripe-like symptoms or jaundice, such changes did not develop with NP207.

Conclusions

1. NP207 appears to have definite beneficial effects in the reduction of tension. It seems to diminish anxiety with fewer side effects than chlorpromazine.
2. Although an insufficient number of patients received both drugs to make a direct comparison, it is the writers' impression that chlorpromazine in equivalent doses is somewhat more effective in reducing anxiety and tension than NP207.
3. NP207 and BOL 148 combined did not show a superior action in the reduction of tension over NP207 alone. Higher doses and a larger series with a different patient group might give better results however.
4. Because of the development with this drug of symptoms resembling retinitis pigmentosa, further research should be undertaken only with extreme caution.

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THE MANAGEMENT OF SIDE EFFECTS OF CHLORPROMAZINE AND RESERPINE*

BY ANTHONY A. SAINZ, M.D.

Since the early days of research with chlorpromazine and reserpine, it has been evident that knowledge and understanding of their side effects is necessary for their efficient use. With both, the incidence is rather high. Usually, over 50 per cent of the patients treated show some side reaction.

In a study of 360 patients** (paranoid and catatonic schizophrenics, obsessive-compulsive patients and patients with anxiety reactions) who had failed to respond to chlorpromazine, and of 90 patients (simple seniles, psychasthenics, manics and asthmatics) unresponsive to reserpine, it was found that failures were due to inefficient administration in about 20 per cent, and that approximately 40 per cent failed because of discontinuation of medication on the appearance of side effects, or because of a combination of the appearance of side effects and inefficient administration. Inability of the medication to affect the psychiatric condition accounted for the remainder.

Three-quarters of the 60 per cent who had been unresponsive because of inefficient administration or side effects or both (or about 45 per cent of the total failures) were again treated. In 80 per cent of these (about 36 per cent of the total failures), marked improvement or recovery was obtained. It may be estimated that close to 50 per cent of the patients whose treatments are discontinued because of side effects are potential recoveries, and may be made actual recoveries by continuing treatment, while intelligently neutralizing or palliating the side-effects. Such palliation can be achieved in most instances. The present paper outlines the procedures found advantageous to date. The problems of dosage and administration have been already dealt with by the author in another paper† and will be discussed only superficially.

*Read at the New York State Mental Hygiene Department Interhospital Conference, Syracuse, April 9, 1956.

**At Marcy State Hospital, Marcy, N. Y.

†Sainz, A. A.: Systematic administration of reserpine, chlorpromazine and ancillary drugs. Paper read at the American Psychiatric Association Regional Research Conference, Galesburg State Research Hospital, Galesburg, Ill., September 16, 1955.

Chlorpromazine will be taken up first because of its wider range of applicability and more numerous side effects. Not all of these, only the most common or important, will be discussed in this outline. The most commonly encountered side effect is the atropine-mimetic effect, characterized by dryness of the mouth and nasopharynx, blurred vision, and constipation. The dryness may lead to nosebleeds. Prostigmin methylsulfate, or neostigmine, 7 to 15 mg. orally, up to three times a day, usually relieves this condition. In most cases, reserpine 0.25 to 1.0 mg. orally, three times a day is even better. Plain petrolatum, or petrolatum with 0.5 per cent hydrocortone, should be applied liberally to the nasal passages.

The second most common reaction is tachycardia, which at times is very upsetting to patients. It is effectively controlled by oral procaine amide (antrenyl), or reserpine. Postural hypotension is best treated by bed rest following each dose of chlorpromazine, for a week or two, at which time it usually disappears. Persistent hypotension, however, responds well to the amphetamines. Frequently, a 10 mg. dexedrine "spansule" suffices to counteract it for a whole day. Postural hypotension is rare, and very marked or sustained hypotension in normotensive individuals is even rarer. Blood pressure reduction is most likely to occur in hypertensives and special care should be used in administering chlorpromazine to hypertensive arteriosclerotics, in whom sudden drops of blood pressure may easily lead to cardiac decompensation or to dangerously low circulatory efficiency. To prevent this complication, if the blood pressure in hypertensive arteriosclerotics is lowered more than 30 per cent below the usual levels, chlorpromazine should be administered only with the patient in bed, and should be given together with dexedrine or paredrine hydrobromide to maintain effective circulation.

Drowsiness is a rather frequent effect. It usually disappears spontaneously in about two weeks, provided the patient is kept at the same or lower doses of chlorpromazine. Most patients become sufficiently alert with the administration of dexedrine, methedrine, or ritalin. About 8 per cent of the patients treated, however, present a persistent and resistive drowsiness which makes it necessary to: (1.) keep the patient in bed at home or in the hospital while adequate therapeutic doses are adminis-

tered; or, (2.) undertreat, assuring the patient of his usual activities (and the continuance of his psychosis or neurosis). The following notes may serve to illustrate.

A 30-year-old paranoid schizophrenic, unimproved after insulin and electric coma, was placed on chlorpromazine at 100 mg., orally four times daily. The patient became quieter, but remained delusional and hallucinated. After two months on this dose, the dosage was raised to 200 mg., P.O., q.i.d., which made him so drowsy that he continuously wanted to lie down, and would go to sleep sitting on a chair, and so forth. Ward nurses and attendants became upset, since his drowsiness conflicted with ward routine. Other personnel also objected because the patient was unable to "participate in the total program." One week later, treatment was discontinued and he was sent to a "back" ward. Two months later, after re-evaluating his case, he was sent to a treatment ward, and was placed on high dosages of chlorpromazine. He was allowed to sleep or was kept in bed as was needed.

One month later he was free from hallucinations and delusions but required a dose of 150 mg., q.i.d., to maintain his improvement. This dose still made him drowsy but this time 15 mg. of dexedrine (spansule) with breakfast kept him sufficiently alert during the day. Two months later, he was on convalscent care on a maintenance dose of 75 mg., q.i.d., which did not make him drowsy.

An 11-year-old girl developed a severe conduct disturbance because of factors of severe rejection in her family milieu. Her anxiety was severe, and this fact prevented psychotherapy. On chlorpromazine, 100 mg., P.O., q.i.d., her anxiety was reduced, and her behavior improved, but she became rather lethargic. Alertness was restored on administering 5 mg. of dexedrine with breakfast and lunch every day. Correction of the family situation led to her recovery in three months without psychotherapy.

The next most frequent complication is the extrapyramidal syndrome commonly misnamed parkinsonism. The earliest stage of this—spinal rigidity and mildly asynchronous gait—is seldom noted. A puffy expressionless facies is cause for concern; and when rigidity and tremors appear, the drug is frequently discontinued, though needlessly. This extrapyramidal reaction is always reversible, and it usually appears before the therapeutic level of dosage has been reached. For example:

A 45-year-old woman, admitted to Marcy State Hospital for her third attack of catatonic schizophrenia, manifested severe autism and suicidal impulses. She had not responded in the past to two series of insulin

and three of electric shock, and she was placed on chlorpromazine. During insulin therapy, immediately preceding drug treatment, she had attempted suicide six times. At a dosage of 1,800 mg., orally, given daily in four doses, she was less autistic but became more overtly suicidal. At a level of 2,500 mg. daily, she remained suicidal and delusional and developed a severe extrapyramidal reaction with bent arms, stiff gait, masked facies, and severe tremors. She also began complaining of marked inner shakiness which was very distressing. After a week at this dosage, her extrapyramidalism became worse, her appetite disappeared, and she showed no psychiatric improvement.

Instead of discontinuing chlorpromazine, as suggested by several staff doctors, pagitane, 5 mg. P.O., q.i.d. was administered; and, by the third day, the extrapyramidal reaction was almost gone. Chlorpromazine was then increased, and the patient showed excellent improvement at a level of 4,000 mg. per day. At present, she shows excellent behavior at a maintenance dose of 1,200 mg. daily but requires pagitane 2.5 mg., q.i.d., to insure the absence of the extrapyramidal symptoms.

Though the milder forms of the extrapyramidal syndrome may be ignored, the more severe forms are sometimes disabling and are always upsetting to patients, relatives, and ward personnel. In the writer's experience, 80 per cent of these reactions subside when treated with antispastic drugs. Parsidol has been found very effective, but most preparations of similar nature are also efficacious.

Allergic reactions respond fairly well to antihistamines and cortisone therapy. In severe cases, chlorpromazine should be discontinued for a week to 10 days but may be re-administered afterward with little chance of the reactions' recurring. Most often, these skin allergies are due to photosensitivity and are better prevented than treated. Patients on chlorpromazine should be shielded from sunlight for at least the first two weeks of treatment. Local application of a cream made up of one part diothane, one part pyribenzamine cream, and two parts cold cream is a good preventive and also is helpful for rashes already in evidence.

Not a side effect, but a complication, is the epileptogenic action of chlorpromazine. Overt and larvel epileptics show either an increase in frequency or an appearance of seizures within a week of starting the drug. This epileptogenic effect is usually self-limiting, lasting from two to four days; but it is wise to administer anticonvulsants, such as dilantin, to affected patients.

It has been noted, however, that chlorpromazine helps reduce seizures in many epileptics, and that even when it increases the frequency of, or provokes, seizures, it eliminates the periods of confusion and excitement that frequently follow them. The epileptogenic effect is more marked in children than adults.

Although its significance is not entirely clear yet, it has been found that patients who have been prevented from getting constipated have shown comparatively few severe side-effects. It is the writer's practice, therefore, to insure adequate bowel elimination; and for this purpose, magnesium sulfate, given before breakfast, has proved more satisfactory and reliable than other cathartics. Recent experiences show that chlorpromazine produces marked choleresis and frequently causes bile concentration with spasm of Oddi's sphincter. It is very probable that this is the precipitating mechanism of the obstructive jaundice sometimes seen during the course of this therapy. Bed rest—to reduce hematogenous hydrostatic pressure in the liver—and prevention of constipation are felt to be powerful deterrents to this type of jaundice. At least in Marcy's last thousand or so of patients, not one case has appeared, although about 20 patients with histories of infectious jaundice were included in this group. Jaundice and agranulocytosis are the only two complications in which chlorpromazine should be discontinued on a permanent basis. However, in two of the Marcy cases, and in four others called to the writer's attention, the drug was continued during the jaundice without problems, and complete recovery of liver function occurred.

Reserpine has fewer side effects than chlorpromazine, and in general, they are easier to counteract. Nasal congestion and salivation are the most common. Privine, applied locally, is the most effective, but administration of atropine, gr. 1/100, orally, four times daily, eliminates the problems in most cases. In severe conjunctival injection, local instillation of 0.05 per cent privine, mixed, in equal parts, with cortisone eye drops, provides effective relief. Diarrhea and gastric irritation respond generally to chlorpromazine, 50 to 100 mg., orally, three times daily; but in severe cases, paregoric with kaopectate three or four times a day is necessary.

Most of these effects of reserpine last only during the first month of treatment and disappear after this time. Drowsiness

and fatigue are fairly well counterbalanced by the amphetamines and, in many cases, by small oral doses of metrazol. Hypotension and bradycardia require a combination of a long-acting amphetamine and atropine; and sometimes bed rest has to be added. For example:

A 30-year-old, wildly excited manic patient was placed on reserpine, 10 mg. intramuscularly every hour. His manic condition began subsiding after four injections, but his blood pressure dropped to 70/30 and his pulse decreased to 60. Therapy was discontinued, but the excitement became acute again within two hours. Two electric convulsive treatments were given later in the day, without effect, and two more the next day, also without effect. Reserpine was again started at 20 mg. intramuscularly every hour, together with methedrine, 20 mg., intramuscularly, three times a day. The patient's blood pressure dropped to 90/60 but stayed there and he fell asleep after four injections. For the next three days, he required only 10 mg. of reserpine, intramuscularly, every three hours; he could be aroused so he could feed himself; and his blood pressure remained at normal levels with one dexedrine spansule (15 mg.) given each morning.

Reserpine, as well as chlorpromazine, produces extrapyramidal reactions, and the treatment is the same as for those induced by chlorpromazine.

Unlike chlorpromazine, reserpine induces a state of discomfort and excitement, named "turbulence" by Kline and Barsa. This is hard to control. In the writer's cases, about 30 per cent of these conditions have been neutralized by increasing the dosage of reserpine until the patient is extremely drowsy and maintaining the patient in this condition until he is over this phase. In about 10 per cent of the turbulent cases, however, small doses of hyoscine, gr. 1/150, P.O., t.i.d., have sufficed to alleviate this state. Though an excellent sedative for geriatric psychotics, reserpine is not a hypnotic, but the addition of gr. 1/200 of hyoscine, t.i.d., or q.i.d., produces excellent results and good sleep.

In peptic ulcer and ulcerative colitis, reserpine is contraindicated. Yet, in some cases it may be used with caution. The writer has found that with very small doses of reserpine, in the order of .25 to .5 mg., t.i.d., the ulcers actually improve or disappear. In most cases, however, it is wiser to premedicate with chlorpromazine, and even give both drugs concurrently, while keeping vigilance as to the possibile reactivation of the ulcer conditions.

Summary and Conclusions

In the writer's experience, a great number of patients fail to show improvement with either chlorpromazine or reserpine because the dosage is insufficient, or too little is given when side effects appear, or therapy is discontinued because of the side effects. About 50 per cent of such patients can receive proper dosages when the side effects are counterbalanced symptomatically; and such patients have shown marked improvement or have recovered. It is strongly, felt, therefore, that great attention should be placed on the neutralization or palliation of side effects, through ancillary medication and nursing techniques—rather than abandon therapy or reduce dosage below therapeutic levels. This is particularly in view of the fact that—save in few and far-between instances—the side effects are merely bothersome, not injurious, and severe complications are few.

It is recognized that side effects cannot be overcome in every instance. Yet the writer's experience has shown that in general they can be mitigated, at least to the point of making them bearable. By this means, more patients may expect relief from their psychiatric problems and the drugs may be used more effectively and economically. The implications of this are of extraordinary importance, not only for intramurally-treated patients, but for those undergoing ambulatory and outpatient treatment.

No attempt has been made here to cover all the known side effects of the tranquilizing drugs, but the more general or significant ones have been described and their handling outlined. Other solutions of these problems are, of course, possible and conceivable, and depend only on the ingenuity exercised by the individual physician. The dosages given are only illustrative, both those of the drugs and of the corrective medication. It must be emphasized that dosage depends principally on the individual response and not on the medication per se.

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INTENT*

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Mind and Matter

Professor Weihofen**, in a round-table statement at this meeting, has questioned the appropriateness of the existing legal concept of intent as follows:

"When the word 'psychology' was coined, two hundred years ago, the prevalent doctrine hailing chiefly from Descartes, was that every (normal) human being has both a body and a mind. Underlying this assumption—which is still the orthodox view today—is a seemingly more profound and philosophical assumption, namely, that there are two kinds of existence, physical and mental. What has physical existence is composed of Matter; what has mental existence consists of Mind, or Consciousness.

"Under the influence of this assumed contrast between Mind and Matter, we tend to refer to ourselves as if we were a body occupied by a person—a Ghost in the Machine, as one English philosopher calls it. We speak, and apparently think, as if inside each of us there is a spirit, which we call variously Consciousness, Reason, the Soul, or some such abstract term. Sometimes we talk as if we are each inhabited by a trinity of such ghosts: Thought, Will and Emotion—or, in more scientific-sounding terms, the cognitive, the conative and the affective aspects of Mind."[1]

Weihofen points out that intellectual processes do not occur apart from the rest of the individual and then goes on to say:

"So with Volition or freedom of Will—a favorite legal presupposition. The concept of a Will inside the body is merely an extension of the myth of the Ghost in the Machine. To describe a man as intentionally pulling the trigger is to say that this Ghost caused the contraction of the muscles of his finger. The language of 'volition' is the language of a para-mechanical theory of the mind."[1]

*Address at the meeting of the Association of American Law Schools, the Hotel Biltmore, New York City, December 29, 1954.

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The Philosophic Background

The issue which Weihofen raises is really whether a defensible system of ethics can rest upon a dualistic foundation.

The position opposite to that of epistemological dualism,* that is, monism, may be expressed either in the form of epistemological realism, in which the world is considered real, or in the form of epistemological idealism, in which it is proposed that only the self is real. From the internal evidence of Weihofen's statement, it is apparent that his prejudice is in favor of a particular type of realistic monism.

Efferent versus Afferent Function

It is interesting to observe that the legal profession is more concerned with the nature of the effecting agent than with the recipient of sense data, who has been the traditional concern of the philosopher and who is now the primary concern of the psychologist and neurologist. Thus, the lawyer asks not the conventional question, "Is it the world which is real or is the world merely a projection of my mind"? but rather, "If the world is real, how is it possible for me to be other than a part of it and therefore devoid of volitional freedom?" The writer thinks that it could be shown that the latter question involves at least two philosophical problems and is, therefore, unnecessarily involved. Undoubtedly, the position one takes with regard to the manner in which the individual becomes aware of his surroundings must determine what sort of conclusion one must adopt about the nature of the effecting agent. It is certainly simpler to arrive at an opinion as to whether one is or is not a realist or idealist by examining afferent processes.

Position of the Expert in Neural Function

"Insofar as neurologists base any theory of knowledge upon their observations, they seem usually to adopt physiological idealism."[2]

The predilection which most neurologists have for idealism is, like that of the man in the street, probably based on affect. The neurologist might replace Descartes' neat phrase, *"Cogito ergo sum,"* with the warmer statement, "I feel, therefore, I am."

*Epistemological dualism implies the nonidentity of the cognitive object (such as the "I" or self) and the sense datum (such as the "not-I" or "world").

This quality of feeling, Russell Brain has chosen to call a "new" function of the nervous system. Without arguing its newness one may pass on to the manner in which he conceives the average neurologist to arrive at some degree of adherence to idealism.

" . . . feeling is directed towards an object, and if actions are to take time the organism must possess an enduring representation of that object. Here we reach the other new function of the nervous system, the representation of the external world. I do not propose to discuss the philosophical aspects of consciousness but probably most, if not all, neurologists accept what has been called 'physiological idealism'. All that we know about the physiology of the conduction of nervous impulses teaches us that perception only occurs when nervous impulses reach the appropriate end-stations in the brain, that these nervous impulses are all much alike and that they are quite unlike the physical stimuli whether of light, sound or chemical character which initiate them. Our perceptions, therefore, are largely a product of the activity of our nervous systems and they are, as we say, 'projected', and perceived as being external to ourselves. This, of course, has given rise to a number of philosophical puzzles, with which we are not now concerned, but, if you accept physiological idealism, you will be prepared to agree that the world which we perceive is a representation of the outer world created to a large extent by the nervous system, and this I would suggest is the function of the brain surface on its receptive side."[3]

Brain may be somewhat restrictive in his selection of the receptive role of the neuraxis. The reason why he has selected the sensory side of the nervous system rather than the entire neuraxis is probably that the principal issue between epistemological monism and dualism arises, as has been indicated, in connection with perception. "In this field it is the apparent independence, the objectivity and the external location of thing-percepts which makes it difficult for many to admit that such things are no more than percepts, not the real and independent physical things at the same time."[4]

Position of the Physical Scientist

Köhler has pointed out that the average astronomer, geologist or chemist—unlike the psychologist, neurologist, psychiatrist or other neural-minded investigator—is likely to be a realist.

"Practically all research in natural science proceeds, I believe, on the tacit assumption that its subject-matter exists outside the phenomenal worlds of all observers. As we have seen, such a hypothesis is not meaningless in principle. On the other hand the scientist cares little for the phenomenological foundations of this assumption. And when he tries to find the properties and laws of transphenomenal entities he does not start with such cases as give direct evidence of transphenomenal existence. Indeed, of these he usually knows little or nothing. His is a more naïve and a more indirect procedure. It also has a wider scope. His tendency is to jump over all epistemological difficulties and to trust his observations and his inferences to provide genuine knowledge of realities beyond all observations."[5]

Models as Explanations of Function

It would seem that questions of this type ought to be solvable on the basis of what we know about the structure and function of the nervous system.

What we know about neural structure depends upon the methods of observation available to us. The manner in which we believe the nervous system functions depends, to some extent, upon such methods but also, and perhaps even more particularly upon analogical reasoning from what we know about how other, non-neural, systems function. Thus, at the present time it is the fashion to apply to the nervous system terms such as feed-back, which have been borrowed from electronics or other fields. These phrases are applied with an air of finality and a satisfaction which suggests the possession of new esoteric knowledge, but the making of such conceptual models has long been an incorrigible habit of man and, like that of the making of books, there is no immediate end of it in sight.

For the ancient Greeks, the word *νευρον* meant either a nerve or a sinew, and movement of the body was supposed to be effected by the pull of these "neurons" or cords. Sensation was thought to be caused by the literal entrance into the nervous system of a sort of object-emanation, entering through nerves which were conceived of as a variety of conduit. At a later date it was thought that the nervous system was a kind of hydraulic apparatus which caused muscles to contract by pumping them full of liquid, whereas

sensory phenomena were caused by sending a shock-wave up a fluid-filled nerve or by causing the latter to vibrate, as a violin string does when plucked or bowed. The tendency to attempt to explain neural function on the basis of various mechanistic analogies is, therefore, old indeed. It has, of course, kept step with progress, and advances in our knowledge of structure have forced modifications and revisions of such conceptual models.

Greco-Roman versions of neural function were of limited, if any, value to the law. The law exempted an insane person from responsibility and transferred responsibility for him and his effects to someone else, but it was not clear in what way the nervous system might be related to insanity. The old Peripatetic division of the "soul" into rational, irrascible and concupiscible elements, located in the head, heart and belly respectively, provided little more than a hint that the brain had anything to do with thinking.

As time moved forward and new physical principles were discovered these were always employed in revising the accepted conceptual models of neural function. Thus, in that optically-minded century—the seventeenth—one finds Thomas Willis developing a highly improbable model of neural function in which the physical laws of reflection played a conspicuous part. Although such blueprints of function had the value of stimulating a few individuals to inquire whether the structure of the nervous system was really of such a nature as to be compatible with the theories proposed, they did not lead to any alteration in legal structure, primarily because they failed to influence medical thinking in relation to insanity.

With the growth of radio communication, following World War I, there has been an increasing tendency to explain neural function in terms of electronic analogies although one rather recent writer, Craik,[6] has preferred to return to mechanical principles.

With the spread of model-making from civil and nautical engineering to aeronautical design, and with the development of practical servomechanisms on a large scale, during World War II, there has been not only a renewed stimulus to analogical reasoning about brain functions but also toward the application of the ultimate in analogy, notably the symbolism of mathematics. It is perhaps inadequately recognized that mathematics can be employed in other than its qualitative, phenomenologically expressive phase

for it can also be made to serve as an unspecific symbol of an abstract or hypothetical concept. Ashby's *Design for a Brain*[7] and Wiener's earlier *Cybernetics*[8] are both examples in point.

Comparison of Symbols

One outgrowth of vacuum-tube amplification has been the elaboration of a set of working hypotheses and facts collectively termed "communications theory." Communications theory is implicit in radio-television practice, and it is not surprising, therefore, that J. Z. Young[9] made an effort to apply certain aspects of it in the course of a series of BBC radio lectures on the subject of neural function—lectures, of course, destined for a popular audience. Young's book might more appropriately have been entitled *Hypothesis and Verification* than *Doubt and Certainty,* for the result of the inductive process, as this manifests itself in the formation of a generality (which is then fitted by trial and error into the existing scheme of things), is what Young calls "doubting." Young's approach to his subject is of some interest to the lawyer. Not only does he examine some hypotheses of how the nervous system might work, in terms of what we know about its structure and in terms of communication theory, but he also returns to the Socratic device, as disclosed in Plato's *Republic,* of comparing the component units of man's structure with the individual elements of society. Thus, as the cell is the unit of structure in man, so man is the unit of structure in society, and what holds for relationships between cells in a body, Young argues, ought to hold with regard to men in a society. The way to learn about an individual man, Young insists, is to find out (in a phenomenological manner) what goes on in his brain and the way to find out about man, as a representative of a group, is to study the behavior of the brains of the group. It would be too specific to say that Young is a realist who subscribes to the concordance theory of truth. His book does not deal with so direct an exposition, or in those terms, but the following quotation would seem to place him in sympathy with that aspect of epistemological monism which has been referred to as the "New Realism."

"We each probably still say, if pressed, something like, 'The central thing that I know is my mind, my experience, my consciousness.' That is to say we refer to ourselves as if we were a

body occupied by a person—the old model of a circle with something inside it. Is it possible that we should convey more information if we tried to do without this whole apparatus of the words of conventional psychology? We can say everything that we want to say quite well without speaking all the time as if we were inhabited by this spirit called the mind.

"One of the principles of science since the seventeenth century has been to try to speak only of that which was observable—to be direct. In a sense the extraordinary discoveries of relativity flow from directness of description. We must not say that a rod has such-and-such a length, but must describe exactly what we have done to measure it. We must not interpose the 'occult quality', as Newton might have called it, of length into our description. May it be that the terminology of psychology consists of a series of occult qualities interposed in this way? They are models, if you like, used for convenience of description; we can do without them when we get better ones.[10]

"Let us try to describe ourselves exactly to each other. We shall find that we can do better than by trying to speak of ourselves as inhabited by a number of pseudo-things such as consciousness, mind, experience, and the rest of them. Of course, this is making the situation out at its worst. Few people speak of the mind as if it were a simple thing. It is a truism that our powers are compounded from many sources. The suggestion is that we should now fully recognize this, face the multiplicity of ourselves and speak less as if we were inhabited by a semi-thing—the mind."[11]

Young is not very clear about how such a solution is to be brought about. Elsewhere[12] he says, "My whole thesis is that our thoughts can conveniently be organized by focusing our attention on the importance of communication and the way that it is ensured by the brain." That way is, for Young, principally a matter of adopting satisfactory symbols for things and their classes and then making comparisons with these.

Considerations such as these point to the inevitable conclusion that there is much about man's behavior which is automatic and very strongly influenced, if not indeed determined, by circumstances outside himself. Some thinkers, who, like Eccles,[13] have a bias toward the preservation of freedom of the will, have been

so impressed by the automaticity of man's behavior that they have sought for a loophole in the physical universe in order to escape from the incubus of determinism. In this they usually follow the lead of Eddington[14] who selected the Heisenberg principle of indeterminacy* in order to avoid the necessity, as he thought, of accepting determinism. That the search for freedom of action, and thus, as some have erroneously supposed, for the lawyer's basis of intent should have to be conducted with instruments designed to detect activity occurring at an order of magnitude below that of molecular size seems absurd; and, indeed, Eddington had definite difficulties with the problem of magnitude. Köhler[15] has pointed out that seizure upon the Heisenberg principle will probably not establish volitional freedom, since the principle of indeterminacy itself is not beyond suspicion, because the conditions which need to be employed to study the situation under investigation themselves introduce a feature of instability into it.

Lack of Necessity of Exclusion

There has been a marked tendency in the writings on these subjects of the last decade or two to adopt a conciliatory attitude toward opposing points of view. It has already been noted in what a restricted sense idealists are such, and over what a limited extent the proponents of volitional freedom are prepared to argue their case. As Eccles puts it:

"It should be pointed out that, in this discussion of the functioning of the brain, it has initially been regarded as a 'machine' operating according to the laws of physics and chemistry. In conscious states it has been shown to be in a state of extreme sensitivity as a detector of minute spatio-temporal fields of influence. The hypothesis is developed that these spatio-temporal fields of influence are exerted by the mind on the brain in willed action. If one uses the expressive terminology of Ryle (1949), the 'ghost' operates a 'machine', not of ropes and pulleys, valves and pipes, but of microscopic spatio-temporal patterns of activity in the neuronal net woven by the synaptic connexions of ten thousand million neurones, and even then only by operating on neurones that are

*According to Heisenberg, who acquiesces in the complete predictability of the "ordinary" world, the behavior of subatomic particles cannot always be predicted with accuracy.

momentarily poised close to a just-threshold level of excitability. It would appear that it is the sort of machine a 'ghost' could operate, if by ghost we mean in the first place an 'agent' whose action has escaped detection even by the most delicate physical instruments."[16]

On the other hand it is perfectly apparent that even the most rigid realist does acknowledge a something to which the first person singular may appropriately be applied.

The suspicion that the distinction between dualists and monists and between realists and idealists may be more apparent than real has occurred to many writers—and a long time ago. Russell Brain expresses this conclusion in the following words:

"Making use of conceptual symbols I say that waves of a certain wave-length and frequency start at a certain spot and pass through space to the retinae of my eyes, there initiating a series of impulses of quite different frequency which pass along the visual pathways of my nervous system and set up a disturbance in the parts of my brain concerned with vision. I then see the red light. The red light in my perceptual 'world' is a symbolical representation of the events in the physical 'world' of which a certain wave-length and frequency are the conceptual symbols, but the events in my brain which cause me to see the red light are quite different from red lights as the physicist knows it. My perceptual 'world,' therefore, is a kind of map. It is not identical with the physical 'world' any more than a map is identical with the country which it represents, but it is able to symbolize it because events in my perceptual 'world' stand for events in the physical 'world'.[17]

"Each of us has his own perceptual 'world'. Your 'world' and mine are different both in time and in content but do have parallel and similar aspects. If you stand half-way between me and a source of sound you hear the sound at a different time from me; hence your perceptual 'world' contains a sound when mine does not, and vice versa. Similarly, another person's perceptual 'world' may contain a phantom limb or a toothache, which I cannot perceive. But if our inferences are made according to the appropriate rules we shall all agree about the physical 'world'.[18]

"If the perceptual world of each of us is to represent the physical world, certain features must be common to both: broadly

speaking, the perceptual world must reproduce the structure of the physical world. In addition, the perceptual world contains features which are purely subjective, however external and independent of the observer they seem to be. It is, in fact, the product of a fusion between subjective and objective elements, a fact which is of great importance in our understanding of animism, magic and art. The qualities with which the savage endows places and objects really belong to them, not in the sense that they are qualities of those objects in the physical world but, that they are part of the objects in his perceptual world, because this is to some extent part of himself.

"The same is true of art. When an artist represents an object, as in painting a landscape or a portrait, he does not merely reproduce the pattern of sensory impressions it produces in him, but that pattern as modified by his own feelings and thoughts. Such a picture is never just a representation of reality: it is a distortion created by the passage of the sensory impressions through the magnetic field of the artist's personality, and this is literally true, since we can regard the artist's personality in neurophysiological terms as the resultant of the extremely complex electrical forces of his brain."[19]

Köhler had already resolved the dilemmas of dualism versus monism and idealism versus realism in what is probably a still more incisive manner. Indeed, it would be surprising if the philosophers had not perceived such a resolution at an earlier date and, as Köhler points out, E. Mach had done so. Köhler says:

"According to Epistemological Dualism all individual percepts, those which we call things as well as the percept 'my body,' depend on transphenomenal events in a transphenomenal entity, the organism. Even the fact of such dependence, however, is in a simple perceptual situation not a matter of phenomenal awareness; only some indirect procedures and conclusions of physicists, physiologists and philosophers lead to the conviction that there is such a dependence. On the other hand, all those percepts appear in a general phenomenal medium, phenomenal space, and as a rule they are there localized outside each other: 'the tree,' for instance, near the 'house,' the 'cloud' and the 'moon' above—and 'myself' rather far from these things, although 'my feet' are in touch with the percept 'ground.' It is certainly no more surprising that the

other percepts appear outside the percept 'my body,' than that the 'moon,' the 'cloud' and the 'tree' appear outside the percept 'house.' Conversely, instead of expecting to find the 'tree,' the 'house,' the 'cloud' and the 'moon' inside 'myself,' I might quite as well expect to see 'myself' inside one of the thing-percepts 'tree,' 'cloud' or 'moon.' Without exception we are dealing here with percepts which have a definite phenomenal location relative to each other, and there is no reason whatsoever why in phenomenal space the percept 'myself' ('my body') should not in principle play the same role as that played by other percepts.

"Thus, astonishing though it may appear, the problem by which so many have been disturbed is indeed no real problem at all. This becomes obvious as soon as we distinguish between the organism as a transphenomenal entity and the 'body' as a percept. To the first refers the statement that all percepts depend on processes inside the organism—where even the word *depend,* just as *inside* and *organism,* has a transphenomenal meaning. To the second, the 'body'-percept, refers the sentence that things have places 'outside myself'—where all words point to phenomenal facts and 'outside' is a phenomenal relation in phenomenal space. Only if we fail to see that one statement is about relations in transphenomenal space (including the organism), while the other is about phenomenal relations in phenomenal space (including the 'bodily self')—only so long can we believe that these statements contradict each other. Confuse the organism with 'self-percept, fail to distinguish between physical space and phenomenal space and you have the great paradox: 'Inside' predicated there contradicts 'outside' found here. I have to add only that the paradox disappears without the help of any special hypothesis."[20]

In summary, whatever we credit ourselves with knowing (either about what we call ourselves or the "outside" world), is the result of a process of representation in our brain, which process is rendered arbitrary by definite limitations in our receptional devices and conducting mechanisms. The only real distinction between the first person singular and what pertains to it resides in the fact that information obtained with and through a certain portion of this receptive-conductive apparatus is quite unsharable with anyone else, a circumstance we learn as we mature and which we characterize by "I" in ourselves and "you" in other

persons. Those experiences that the "I" shares with "you," with a high degree of accuracy and that, therefore, transcend the vague empathic "me in thee" of Omar, are characterized as phenomenological. That the sharing of relatively common experiences must be on a relatively unequivalent basis (as in the case of a color-blind person communicating with a person with relatively good color vision) is not very widely recognized and is easily lost sight of.

There is no distinct line between sharable and unsharable experiences. Some of our most intimate experiences, such as blood pressure alteration, can be more adequately perceived by others than by ourselves, providing those others are equipped with the proper apparatus. Moreover, it may very well be questioned whether the glasses on the end of my nose are less of me, because they are more easily detachable, than the lens in my eye. In certain circumstances, such as cataract, the former may be of definite advantage and the latter a handicap. Or again, is the microscope which extends my personal experiences a part of me? There is good evidence that the motivation of man is subject to considerable variation in this respect. Impersonal objects, as well as other persons, or parts thereof, may come to have a greater significance to the individual than parts of himself have for him. There is an especially strong tendency for the individual to depersonalize a part of his body when, because of conductional or representational failure, he can no longer receive information from such a part, it is a kind of physiologic divorce.

There is, in short, no absolute, no hard and fast, or even, for a particular individual, no constant distinction between "I" and "not-I." Such a distinction is relative, and qualitatively as well as quantitatively variable. It varies with culture, with age and even, in the same individual, with motivation. It follows that distinctions between dualism and monism and between realism and idealism can only be absolute from the philosophical point of view. It cannot be overemphasized that, even when such qualifications are insisted upon, it is found that the arguments of the different points of view hold only for segments of a continuum, which segments are not sharply demarcated from one another, and that a comprehension of the whole can only be approximated by avoid-

ing an attitude of exclusion toward segments other than those under consideration.

Is Intent Dependent upon Volitional Freedom?

The assumption that what is legally called intent is necessarily dependent upon the existence of a notable degree of volitional freedom seems open to question. Intent may be defined as the purpose toward which a course of action was apparently directed, and it can, therefore, only be determined on an apparent basis and in retrospect. The fact that the organism may or may not be free to choose, initiate and pursue such a course of action is immaterial. The activities of insects are evidently so completely determined by conditions of time, temperature, luminescence, sound and tactile sensation that they can scarcely be said to possess any notable degree of volitional freedom. Nevertheless such organisms may quite justifiably be said to act with intent when the forces which operate upon them co-ordinate their activities toward some definite goal, particularly if this has a survival value, such as escape. On the other hand a cricket which leaps into my picnic lunch has arrived at that particular location innocent of intent. The intent of the cricket was, presumably, merely to escape because it was disturbed by someone walking through the grass nearby.

Let us assume that it could be demonstrated that the commission of a particular deviation from a standard pattern of behavior was, in a particular individual case, quite automatic. In such an event, we would still be faced with the necessity of having to decide why that individual did what other people did not do and of finding a means for preventing him, and others like him, from doing it again. We should in short be faced with exactly the same problems with which we are presently faced. That is, we should have to institute measures to train individuals so that they would react differently. We should have to alter, as well as we might, any conditions in the social situation which might lead toward behavior deviation. We should have to institute countermeasures to prevent the deviation from occurring in individuals disposed toward it, and we should have a mechanism for the detection and removal of such individuals from society. It really would not matter whether such a person did or did not exercise

any element of choice in connection with the particular course of action followed. Neither would such a consideration enter into a determination of the existence or absence of intent.

Would the Establishment of Complete Automaticity on the Part of Individuals Have Any Practical Bearing upon Legal Principle?

Having, I suppose, disposed of the necessity of worrying whether the machine is automatic or is "worked" by something else and having demonstrated, I trust, that these are only different facets of the same problem, I would now like to move on to the larger proposition of whether it would have made any difference from a legal point of view if the situation were such that, on the one hand, man were a mere machine worked by an influence entirely outside himself or, on the other, were a completely automatic device. The first proposition is that expressed by Plato in the *Laws* (644E), "Each of us living creatures is an ingenious puppet of the gods, whether contrived by way of a toy of theirs or for some serious purpose." Even in such a case, it will, I suppose be admitted, a large number of the puppet's processes of daily living must of necessity be carried out in a highly automatic manner, that is by processes built into it to make it to some extent self-operative.

Indeed, in a not inconsiderable number of legal actions, such as for negligence, the individual may literally have slept through the events which precipitated the action. In a large proportion of liability actions, especially in those involving the use of some machine which injures someone other than the operator, the operator may have functioned in a manner scarcely more personal than a part of the machine itself. His actions occur with the rapidity of reflexes, are interdigitated with the characteristics of the machine and are called forth by sensory phenomena which may be highly arbitrary (such as dial reading), and in actual conflict with other sensory phenomena reaching him (as in blind flying). The man is, in fact, functioning as a part of the machine, rather than as something apart from this. It may be argued that the factor of choice, assumed to exist in situations where judgment for damages is awarded and there is negligible or non-existent intent, resides in antecedent circumstances. The attractive hazard should have been removed, or the pilot should not have taken

his plane up in that kind of whether, or he should have come down when the weather soured. The fact that insurance is available against loss from judgments handed down in such circumstances indicates that society does not put much confidence in man's ability to avoid that kind of trouble.

Since we cannot take out insurance, with any of the more reliable carriers against being penalized for a felony, it would appear that the assumption is that one is ordinarily responsible for one's acts and that behavior leading to the commitment of crimes is thus entirely avoidable in ordinary circumstances. This assumption is the case if a person is responsible for his acts, and it is further assumed that, people are either responsible or they are not. The writer has previously examined one aspect of the latter assumption and has pointed out:

"In the strictest sense there can be not only no dividing line between responsibility and irresponsibility but also no clear demarcation between any degrees of gradation between the two conditions. At the extremities of the scale of relative responsibility, there certainly are no individuals who are fully responsible or irresponsible throughout their lives for all their acts and in all circumstances. Nevertheless, from a practical point of view, it would be expeditious to divide the range of responsibility into three, instead of two, territories, and to recognize an area between relative responsibility and irresponsibility. The essential characteristics of persons found in this behavioral area are that—while they do not qualify as irresponsible by the two principal tests used in this country—their pattern of behavior can be confidently expected to bring them into continued conflict with the mores of their particular social system.

"Such persons do not qualify as irresponsible on the basis of the 'right and wrong test.' They do know the nature, consequences and wrongfulness of their acts. Neither do they clearly qualify as irresponsible under the 'irresistable impulse' test (in the 18 jurisdictions in which this is valid), for they do not entirely disregard the nature of the surrounding circumstances in committing their acts. On the other hand, such persons often have a confused idea of the social character of their acts or a pallid appreciation of their implications. Frequently, they also exhibit a low degree of resistance to transgression. From the physician's point of view

they fall into several classes. These are (1) the prepsychotic individual; (2) the convalescent psychotic; (3) individuals with subclinical psychotic traits, with or without evidence of organic damage of the brain; (4) psychopathic personalities; and (5) psychoneurotics (severe)."[21]

What, in effect, such a classification points up is that for practical purposes there is a very large group of noninstitutionalized individuals (and it must be remembered that in this State 10 per cent of the persons born in this year will be institutionalized at one time or another in their lives*) who are not trustworthy.** If this number of persons is added to those institutionalized—and if it is remembered that membership in both groups changes constantly—it seems probable that about half of the population at any given time would have to be assumed to be functioning in an undependable manner.

Converted to the terminology used by Ryle, and adopted by Eccles and Weihofen, this means that at least half of the population cannot follow the instructions of the ghost in the machine, if there is a ghost. If there is no ghost, this means that the machine operates at an inferior level of efficiency, failing to sort and classify properly, and producing bizarre results which—while they follow the consistency of physical law — result, from the standpoint of the purpose of machine-design, in a frustrating and baffling, consistent inconsistency. Thus, either as servants or independent agents, these human machines are functionally, and often structurally, defective. It is this part of the population which is responsible for a very large part of the social unrest in any area. Moreover, the presence of this cohort accounts for most of the work of the lawyer, for it is directly responsible not merely for most crimes, but also for a great amount of legal backing and filling and general shuffling about, some of which is initiated by members of the inefficient group and some of which has to be activated in order to keep up with the pointless and ineffectual blunderings of its members.

*Assuming that there is no notable alteration in either the incidence of mental illness or its morbidity characteristics.

**It is estimated that for every person in an institution, there is another equally as sick who should be institutionalized, but who, because of family situation or otherwise, is not admitted to an institution.

Seen in this light, the lawyer's real problem is not a question of whether there is or is not a ghost in the machine which is man, but rather whether the machine is functioning reliably. What difference, indeed, can it make how exact and detailed the directions given to the machine may be if it cannot or does not carry them out? Thus, whether it functions autonomously or under direction, an inadequate machine can scarcely be expected to perform in a standard manner; and it is performance, the effector side of man's behavior, with which the lawyer is really concerned. That is why Weihofen talks about a motor act such as trigger-pulling and not about perception or sensory input, which the philosopher is exercised about. It is the writer's contention that it is not merely motor or sensory function but also what goes on between these which affords a real opportunity for bringing the philosopher and lawyer together. One scarcely needs to go beyond the elements of performance-rating to deal in an effective manner with man as a social machine. In fact, every experienced and well-balanced police officer, every just and intelligent magistrate and every properly motivated penal officer knows and does just that. There is a difficulty, perhaps, in that such officials often perceive their basis for evaluation rather obscurely, justifying their opinions pragmatically and feeling rather defensive about the apparent lack of theoretical basis for them. Moreover, such valuable people are at a disadvantage among unscrupulous, maladjusted or emotionally-motivated colleagues—who twit them for following a course of action which they find difficult to rationalize in terms which are meaningful to the misfits on the police force, on the bench and on the prison boards—who view everyone else as an opportunist.

It may be objected that what has been said is an argument of defeatism in that it would seem to consider departments of correction useless. It may be asked, "Of what use is it to 'punish' a defective machine?" The writer would not agree to having what he has said characterized as defeatist and would not agree that departments of correction function to subject "machines" to punishment. Neither does he recommend that the jails be closed. Even though there may be little reason to believe that prisons "correct" anything, it is necessary for a community to have some sort of custodial arrangement for the acceptance of such machines as may be defective but not absolutely unreliable. Moreover, and here one

may appear to resurrect the ghost again, it would certainly appear that a system of law, re-enforced by police, courts and jails, does act as a deterrent to crime. The apparent paradoxes that cities with the most complete law enforcement agencies have a high percentage of crimes and that capital punishment has not produced any appreciable restriction in the number of murders committed have often been cited to prove that crime is not preventable, but there are too many uncontrolled factors in such situations to allow one to draw any solid conclusions.

It is not difficult to find a biologic rationale for a system of law enforcement. The existence or non-existence of such a mechanism is a datum which is handled by the nervous system as is any other datum. If the organism is unable to handle data clearly, such a datum will not have any particular value. If the organism can handle data profitably, this datum will be matched with the other data at hand; and, if the presence of a law enforcement organization has an inhibitory significance, it will be effective just so long as that significance continues. Should it be discovered, for example, that although the police arm is effective the courts are venal, or should a sentence be immaterial to the prisoner, the inhibitory value of the law enforcement mechanism, of course, is lost.

Effective law enforcement agencies have no corrective value for faulty organisms. They rarely remove such from society, but they do act as deterrents for properly functioning organisms which have not been trained in such a manner as to find in the ordinary conditions of society an adequate stimulus to channelize behavior along accepted lines. They also serve to fix conventional standards of behavior in a society. While such standards are always arbitrary and often unenlightened, some agreement upon conventions is necessary in order to avoid breakdown in communications between individuals and to insure some sort of facility in what might be called the movement of social traffic.

Contributions from Neural Structure and Function

From the point of view of the structure of the nervous system, there is no distinction between the "I" and "not-I." Whether sensations are produced from events from within or without the body, near at hand or far away, is something which must be learned; and such learning progresses in a frame of cultural reference ap-

propriate to the culture of the individual and, therefore, not always in the same manner. The legal structure surrounding the growing individual forms a part of the cultural pattern, and what the person comes to call "I" and "you" and "him," "mine," "yours" and "his" is therefore determined more by philosophical implications inherent in his culture than by the structure or function of his nervous system. He gradually learns that what he calls "I" is a set of data about which only he has rather precise knowledge and that what is "not-I" refers to data which he shares more or less completely with others. There is, however, a vast body of data which are only sharable in some of their aspects and under particular conditions (as during pregnancy) and about which the quality of identity or non-identity is confused and variably interpreted. Indeed, the neural system may make some very startling "mistakes"—by legal standards—in which portions of a person's own body may be regarded as quite foreign to the self or stimulation of a portion of the body may be felt as if it occurred in another part and as if this other part were somewhow diffused in some inanimate object close by. There are rather simple neurophysiologic explanations available for such apparently startling interpretations.

Thus, from the point of view of the nervous system, the distinction between "I" and "not-I" is a man-made one, depending upon categorizations made on a philosophic basis which postulates the existence of boundaries which are at best imperfect, broad and variable. This does not mean that it is improper or impossible to designate certain data as "I" and others as "not-I," but it must be realized that these data form part of a continuum which contains no dividing line—and that any attempt to define one results in a definition which can only have utility for the special set of circumstances, both as to space and time, in which it is defined (such as the possession of a deed) and that any alteration in these requires a re-definition. Since the number of such alterations (whether the deed was stolen, whether it is a warranty deed, whether the holder is the person specified, whether the warranty was valid, whether fraud was involved, etc., etc.,) are even more numerous in physiology than in the construct of the law, it will be seen that it is best not to insist upon the acceptance of some parti-

cular rigid philosophic construct if one wishes to make any progress in understanding behavior.

A similar situation exists with regard to the apparent problem of free will or, more properly, the question of determinism versus indeterminism. The events preceding the performance of a particular act by an individual may be simple, uncomplicated, direct and almost entirely the result of reaction to impersonal data, or they may be quite the opposite. The more of the "I" which characterizes these events, the more the resultant is said to be an act of will. Just as there is no clear boundary between the "I" and "not-I," there is none such between acts involving volition and those which do not. It would be equally meaningless to say that mankind does not possess a free will as to say he does. What mankind possesses is an awareness of the complexity of "I-data," and the extent to which they are involved, in the events leading up to a motor act. This he calls volition. His culture similarly designates by that term the apparent absence of involvement of personal factors antecedent to a motor act. Because of these conventions it is difficult if not impossible to characterize any train of events involving complex "I-data" as occurring apart from the exercise of volition, for it would then be necessary to develop a new term to reflect the difference between such a situation and one which is quite direct, possesses little complexity and involves few, if any, "I-data." The extent to which voluntary acts correspond to what the "correct" response in a social pattern may be is an accurate measure of the machine's past capacity to acquire, store and sort out sense data.

Conflicts as to what the "correct" response may be will, of course, arise whenever there is more than one way of assorting such sense data. Should they be assorted in accordance with the apparent immediate best interests of the organism or, if the organism is able to perceive a long-range point of view, in accordance with that? Should one follow the rigid code of the Pharisees or yield to the warm spontaneity of the Samaritan and be criticized by priggish neighbors? Should one alter one's estimate of what is proper as scientific knowledge progresses, or is it one's duty to cling to the criteria of one's fathers? These and all the thousands of apparent dilemmas which face mankind at every turn will be solved by the organism as best it can, with what data it can collect,

and in accordance with its inherited and previously-acquired patterns of behavior and values. What happens when the organism does act will be what is considered a voluntary act and will in turn determine how behavior will be ordered in the future.

It follows from what has been said that the structure of the law is fundamentally arbitrary and unnaturally conventional. What is right and what is wrong cannot be determined unless one inquires, "With regard to what and under what circumstances?" Even then it may be very difficult to establish a clear fixed boundary between the category labeled right and that marked wrong.

All of these considerations are in accordance with the present-day practice of the law, but occasionally a legislator appears who imagines he can draw such a boundary, or a jurist gets the notion that he knows why a particular person did what he did and, very, very commonly—all too commonly—a policeman imagines he knows what a citizen *should* be doing. In such circumstances, it is well to remember that the nervous system, and thus society, has its own rules, and that these cannot be altered by passing laws. Justice, the writer would venture, is still much the same as it was in Plato's day—an all-embracing virtue dependent upon knowledge—and since the making of laws always is a very tardy process which must await the wide diffusion of knowledge, it is not surprising that we have not yet paid much attention, in the law, to how the nervous system has been put together and how it works and that we still try to force it into unprofitable and often unpleasant channels, from which it is usually ingenious enough to find some variety of escape.

One final word: From what has been said here it may be supposed that the writer is of the opinion that the personality and behavior of the individual is exclusively determined by the nervous system. That he has not dwelt upon other aspects of the determination of behavior, and, for that matter, upon very, very many other interesting extensions of the foregoing ideas, is due entirely to the inevitable restriction of time and space which, in this instance, must needs be inexorable "not-I" determinants of the writer's own present behavior!

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RESISTANCE TO LYSERGIC ACID IN SCHIZOPHRENIC PATIENTS*

BY HERBERT S. CLINE, M. D., AND HARRY FREEMAN, M. D.

The present study was instituted to compare the sensitivity of schizophrenic patients to the administration of lysergic acid diethylamide (LSD-25), with that of normal individuals. A variety of reports on normal subjects indicate that they exhibit clinical psychiatric effects of LSD-25 in doses of 10-100 mcg.[1-12] While most clinical studies show effects from 25-50 mcg., the careful psychologic studies of Abramson, et al.[9-11] show that in comparison with placebo administration, 100 mcg. is more consistent than lower doses in demonstrating psychological abnormalities.

So far as schizophrenic patients are concerned, the literature is controversial. Some investigators have noted abnormal behavior, using the same range of doses which are efficacious in producing changes in normal subjects.[3, 4, 13-17] Others, however, state that schizophrenic patients show milder reactions in this range of dosage, or need larger doses to produce psychological changes, both findings indicating some degree of resistance to the drug.[1, 4, 12, 15, 18]

There has been published no quantitative investigation of the problem of an elevated threshold to the drug in this psychosis, and it is for this reason that this study was organized.

The subjects studied were 34 men and women admitted to Worcester (Mass.) State Hospital with a diagnosis of schizophrenia. The data on the sub-type, sex and duration of illness are shown in the accompanying table. There were 18 men and 16 women—hospitalized from one month to 19 years, the average being 5.6 years. Two-thirds of the population were institutionalized for more than two years, so that the population is essentially one in which the psychiatric condition has become chronic.

The patients were tested on their own wards to maintain familiarity of environment and were permitted to engage in routine ward activities whenever feasible during the period of observation.

In determining the degree of reactivity of the patients, various autonomic phenomena were noted, such as trembling, flushing,

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Sub-type, Sex and Duration of Hospitalization of 34 Schizophrenic Patients

Diagnosis	Number	Sex	Years of Hospitalization
Schizophrenic Reaction			
		M	.08
		M	.24
		F	.64
		M	.72
		M	1.0
		M	1.0
Acute Undifferentiated	7	M	2.0
		M	1.0
		F	1.0
		F	9.0
Simple	4	M	12.0
Catatonic	1	F	.5
		M	5.0
Hebephrenic	2	M	7.0
		M	2.0
		M	3.0
		F	5.0
		M	7.0
		F	10.0
Paranoid	6	F	19.0
		F	5.0
		F	5.0
		F	5.0
		F	7.0
		F	10.0
		M	10.0
		F	12.0
		M	15.0
		F	15.0
Chronic Undifferentiated	10	M	19.0
		M	.08
Residual	2	F	.08
		F	.64
Schizophrenic Affective	2	F	1.0
Total	34		
No. of Males		18	
No. of Females		16	
Average Hospital Duration of Group			5.6
Average Hospital Duration of Males			4.8
Average Hospital Duration of Females			6.7

sensations of cold and warmth, numbness, paresthesias, hunger and nausea. These symptoms and signs were observed either just before psychological changes occurred, or they coincided with them. The criterion for a threshold dose, however, was that at which psychic changes occurred, such as alterations in the behavior or thought content of the individual, including the admitted presence of delusions, illusions, hallucinations and other sensory misperceptions. This depended, of course, largely on the ability or willingness of the patients to communicate their unusual sensations. In all patients who were considered to have responded to LSD-25, some autonomic responses were noted. In the others, who did not reveal any psychiatric changes at the dosages used in this study, such phenomena were seen in three.

Method

Since in normal subjects the usual effective dose of LSD-25 ranged from 20-90 mcg., the initial procedure was to start with a dose of 50 mcg. and increase this by 50 mcg. daily until psychic changes were noted, up to a maximum of 300 mcg. In view of the fact that many patients did not respond to the lower doses, the initial dose was later increased to 150 mcg. and finally to 200 mcg. When a psychological reaction occurred at this higher initial dose,

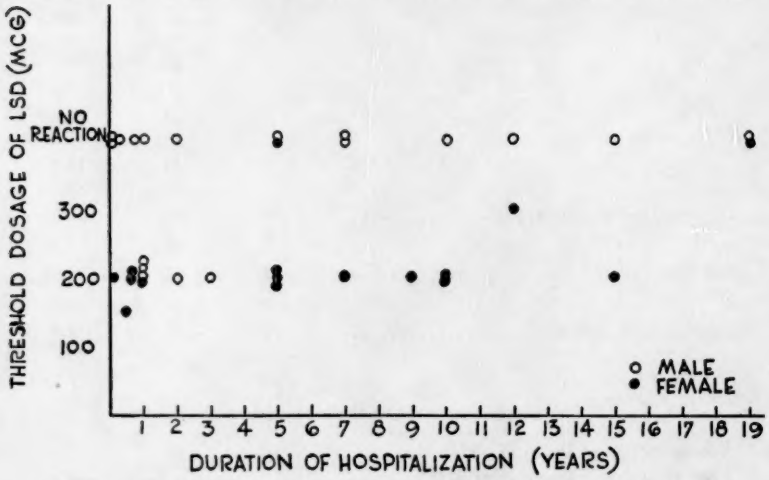

Figure 1. Distribution of threshold dosage of LSD by sex and duration of hospitalization

subsequent dosages were reduced by increments of 50 mcg. until the threshold dose was reached.

Results

The results of the threshold dosage study are shown in Figure 1. Of the 34 schizophrenic subjects, 19, or 56 per cent, showed psychiatric reactions at a dosage level up to 300 mcg. Of these 19, one showed a reaction at 300 mcg., 17 showed reactions at 200 mcg., and one at 150 mcg. In this group of patients only one showed a reaction at a dosage lower than 200 mcg. Larger doses than 300 mcg. were not administered in this study. Thus, in 15, or 44 per cent, of the patients, there was no deviation noted in behavior from that observed previous to the administration of the drug. It is apparent that these results indicate that schizophrenic patients react only to higher doses of the drug than are reported to be effective in normal individuals and, in fact, almost half of them show no change at three to four times the effective normal dose. Thus, a definite resistance to the drug is evident.

The relationship of the threshold dose to the duration of illness was examined. In Figure 1, is shown the length of hospitalization of the individual patients and the threshold doses of the drug necessary to produce psychiatric changes in behavior. No relationship was noted between the two factors. There are non-reactors in the early cases as well as in the late cases. Savage[4] has noted lesser reactions in chronic, than in acute, schizophrenic patients in doses up to 100 mcg. but the present data do not seem to bear this out.

There is a curious relationship between the reactivity of the individual and sex (Figure 1). Of the 19 reactors, 14 were women and five were men. Of the 15 non-reactors, two were women and 13 were men. Thus, a greater sensitivity to lysergic acid is noted in women. The distributions of age and duration of hospitalization were essentially the same for both sexes. There was some difference in the distribution of the sexes by sub-types (Table 1). In the acute undifferentiated group, there were six men and one woman. In the chronic undifferentiated group, there were three men and seven women. Thus, in the two largest groups, the acute cases tended to be males, and the chronic cases, females. Since in the two groups, the men tended to be non-reactors (eight out of

nine) and the women tended to be reactors (seven out of eight) the chronic group seemed to be the more reactive because of the predominance of females. This conclusion can only be verified, however, by the accumulation of a larger series of each sex. Hoch, et al.[16] noted a greater reaction to a given dose in the well-preserved, than in the deteriorated, group, which seems contrary to the present findings, but again, the writers' data on this point are complicated by the difference in response of the two sexes. At present, the writers have no explanation for the apparently greater sensitivity of the female organism to LSD.

A question arises as to whether the present technique of administering LSD in increasing doses every day produces a tolerance to the drug which might invalidate the conclusions. Savage[4] has stated that, on repeated daily administration, a tolerance usually develops. Isbell, et al.[19] noted a tolerance to the drug after daily administration for seven days, but one which was lost after discontinuance of the drug for three days. Since this factor would especially affect the results obtained in those patients who did not react to the maximum dose of 300 mcg., seven of the 15 non-reactors were again tested with two doses of the drug, 100 and 300 mcg., one week apart, one to six months (average three months) after the original threshold study was made. None of these pa-

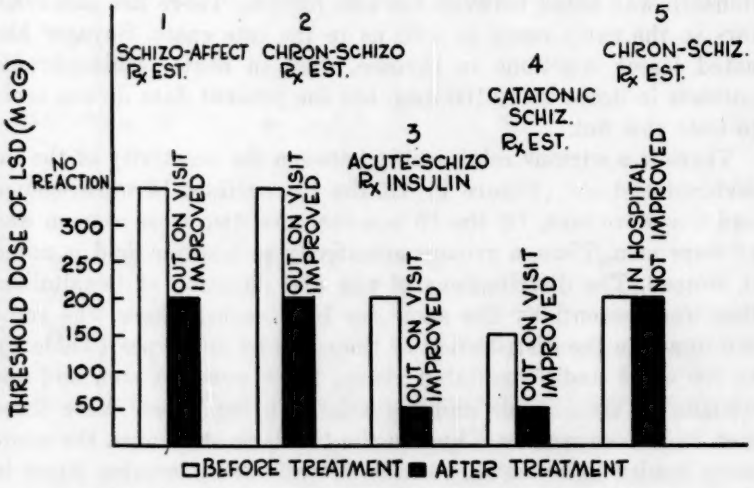

Figure 2. Effect of treatment on LSD threshold in five patients.

tients reacted to the drug. Thus, in these schizophrenic patients, the resistance to the drug was maintained and was not apparently due to the previous technique of daily administration.

A possible relationship between the clinical status of the patient and the sensitivity to lysergic acid was investigated. Five female subjects had threshold dosage measured before and after treatment with electric shock or insulin coma (Figure 2). The second test was done one month after cessation of therapy. In four women in whom there were clinical remissions sufficient to enable the patients to be sent out of the hospital on visit status, the threshold after treatment was distinctly lower than that before treatment. The fifth patient did not improve after electric shock treatment and showed no lowering of the threshold to LSD-25. This trend toward increased sensitivity to the drug with improvement in the clinical status is interesting, but a larger series must be obtained before any definitive statement can be made. It is, of course, possible that the parallelism between the two phenomena may have been purely coincidental, but the persistency of non-reactivity to 300 mcg. of LSD in seven patients whose psychiatric status was unchanged lends some support to the possible interrelationship of the two factors.

Discussion

The data indicate that the responsivity of schizophrenic patients to the administration of lysergic acid is less than that of normal subjects. The development of tolerance to the administration of the drug is not a factor. The data, however, are not conclusive in determining to what extent the lesser sensitivity to the effects of the medication is due to the patients' unwillingness or inability to communicate the presence of abnormal sensations. It would not seem likely that the increased tension built up by these large doses could be successfully suppressed so as not to be evident on careful psychiatric scrutiny, if it were assumed that the threshold was not increased. On the other hand, the question can be definitely settled only by further research to determine whether the material is adequately absorbed and affects the nervous system of the patients to the same degree as it does in normals.

The cause of resistance to the drug leads to speculative realms which are beyond the scope of this paper. Whether the insensitivity is part of the general lack of reactivity exhibited by these

schizophrenics to stressful situations, or is a special instance of abnormal enzymatic function in the central nervous system must await the further investigation suggested.

The diminution in threshold which occurred in the patients who improved presents another fascinating problem. While the series is too small to be anything but suggestive, the trends are at least in the right direction, and, if confirmed, certainly imply a physiological imbalance during a certain stage of the psychosis which is corrected as the patient improves. This phase is undergoing further study.

Summary

A study was made of the sensitivity of 34 schizophrenic patients (18 men and 16 women) to doses of lysergic acid diethylamide, varying from 50 to 300 mcg., to determine a threshold dose which would produce psychiatric changes. Nineteen (56 per cent) of the patients showed psychologic reactions after administration of the drug in dosages varying from 150 to 300 mcg. Fifteen (44 per cent) showed no effects at the highest dose given—300 mcg. Tolerance to repeated administration of the drug was not a factor, since repetition of the maximum dose, 300 mcg., to seven of the non-reactors three months later again resulted in no reaction. Women were more sensitive to the drug than men. There seemed to be a parallelism between the degree of sensitivity to the drug and the psychiatric status of the patients, since four patients who improved after shock therapy reacted at lower doses than during the acute psychotic stage.

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COMMUNITY RESPONSIBILITY FOR MENTAL HEALTH IN BRITAIN, THE NETHERLANDS, AND NEW YORK STATE*

BY ROBERT C. HUNT, M. D.

When I was honored by being asked to lecture in memory of an old friend and associate, I was asked to play the role of minor prophet. From such a role, one must expect some oversimplification for effect, some sacrificing of scientific objectivity. You must also hold my employer blameless, since nothing I have to say necessarily reflects the official views of the New York State Department of Mental Hygiene.** I shall present to you an assortment of facts as to where we are and where we have been in mental health work. Then I would like to think aloud, speculating as to what these facts mean, what action they call for, what new viewpoints they point to.

Let's look for a few minutes at the historical events that led up to our present situation, using New York State as a typical example. One hundred and twenty-five years ago there was not one state mental hospital in New York. For perhaps 50 years before that, there had been important medical advances in the treatment of "insanity" in a few spots in Europe and in America. There were a few first-class private mental hospitals, but for the great majority of the people, mental illness was a tragic, one-way street into the poorhouse or the jail. It was a time, however, of social ferment and of troubled consciences, with many eloquent voices calling for reform. Wide publicity was being given to reports from some hospitals claiming a high percentage of cures in early cases. A doctrine which was put forward with great force was that we must provide public hospitals for the insane, not only as a matter of humanity but also as a means of saving money.

The argument went this way:

It has been proven that most of the insane can be cured if treated early enough by the most modern medical means. Simply putting them in poorhouses condemns them to incurability and condemns the taxpayer to support them for the rest of their lives.

*From the New York State Department of Mental Hygiene, Albany, N. Y. Delivered as the Kenneth K. Slaght Memorial Lecture, in Rochester, N. Y., November 15, 1956.

**Dr. Hunt is assistant commissioner of the New York State Department of Mental Hygiene.

It would be cheaper to build a hospital to treat the insane, cure them and get them off the taxpayer's back. It was this type of reasoning which led to the founding of the first New York state hospital, the Utica Asylum, which was opened in 1843.

Why was this a *state* hospital? Apparently there was no serious consideration of giving the job to any other level of government, and we can make a pretty good guess as to the reasons. Most of our state was thinly and unevenly populated. Furthermore, our people were poor, most of them scratching a bare living in this raw, young nation. With few exceptions, therefore, no political subdivision smaller than the state had the resources for such a task.

This first state hospital did a good job in those early days. It was small by today's standards, and the medical superintendent knew all his patients intimately. Patients were treated with sympathy and understanding, and every effort was made to keep them occupied and happy. And the hospital staff got results. They did succeed in getting a lot of their patients well and home.

However, despite its treatment success, this state hospital did not solve the problems it was expected to. It concentrated its efforts on a small select group of recent, supposedly curable cases, while the great majority of the insane were considered incurable, not worth doing anything for. In 1855, for example, out of 2,123 dependent insane in New York State, there were only 296 in the Utica Asylum. Most of the rest were still in county jails and almshouses. In that year of 1855, the county superintendents of the poor called a convention to deal with this problem. They there resolved, "That the state should make ample and suitable provision for all its insane not in condition to reside in private families." They were understandably a little tired of having to carry most of the burden while taking most of the abuse from crusading reformers.

The issue of who was to take responsibility was debated with great heat during the latter half of the nineteenth century. To many concerned with the plight of the mentally ill, "county" was a dirty word synonymous with neglect, corruption and hopelessness. The state seemed endowed with magical powers to cure all the evils of county care. Under this kind of pressure, New York State, in 1865, opened the Willard Asylum for the Incurably In-

sane to take the chronic cases out of the poorhouses. This by no means satisfied everybody. The counties still had to pay the state to take care of their patients and some counties protested that they could give just as good care in their own institutions and at a lower cost.

The pressures continued to mount for the state to take over the entire burden. Finally the State Care Act of 1890 went the whole way, giving to the state the entire responsibility and the entire expense of hospitalizing the poor and indigent mentally ill. Existing county institutions were taken over, new state hospitals were opened; and, within a very few years, every patient had been removed from county facilities into state hospitals. This established the pattern which has been in effect ever since, and most other states followed this design. Most of us now living have never known any other system and have usually taken it for granted that this is the only possible pattern for doing the best job that can be done.

I have spent most of my professional career in the New York state hospital system and am proud of it. Our hospitals have always been among the best public mental hospitals in the country and have always pioneered in new developments. They began admitting voluntary patients 50 years ago. Our hospitals have operated outpatient clinics in their districts for 40 years, and the department has provided traveling child guidance clinics for about 30 years. Our hospitals were among the first in the world to use malaria treatment, insulin shock, metrazol, electric shock, lobotomies and, now, the new tranquilizing drugs. Certainly the hospitals have never been perfect and never will be, but most of us working in them have always felt that they were good places for sick people to enter and that we were getting just about as good results in treatment as anyone else. We have resented the sweeping criticisms directed at state hospitals in recent years, feeling that they were almost entirely unjustified, for our state at least. "State hospital" has recently become just as dirty a word as "county" was one hundred years ago. On countless occasions, I have appeared before PTA groups and preached this sermon: Mental illness is an illness like any other and should not have any stigma attached to it. Your state hospital is quite genuinely a hospital for the treatment of illness and has a good record of success

in treatment. Anyone who becomes mentally ill should be placed in the state hospital as soon as possible. Perhaps the most important single procedure for mental health is to diagnose illness early and put the patient in the state hospital for treatment.

Now I am not so sure. My colleagues and I used to agree that there was nothing wrong with our own particular state hospital that more generous appropriations could not fix. Now I am not so sure of that either.

A series of experiences in recent years has little by little profoundly altered my own concepts as to the place of state government in mental health and as to how state government can best discharge its responsibilities to its citizens. These experiences are perhaps worth recounting because they are fairly typical of influences which have come to bear on many an American psychiatrist with resulting changes in philosophy.

The first experience which shook my preconceptions was strangely enough the Army of the United States. Early in World War II a colonel of engineers at Fort Belvoir became disturbed over the high rate of psychiatric casualties among the trainees, and impressed with how rarely the psychiatrists were able to restore patients to useful function once they got them in the station hospital. With some difficulty, he persuaded a psychiatrist to leave the hospital sanctuary, and set up a mental hygiene service in the line organization. This worked so well that the idea was picked up by the Surgeon General's office, was extended to other posts, and I was assigned to organize and operate such a mental hygiene service in an infantry outfit. This experience sold me completely on the army doctrine that "mental health is a command responsibility." This is a concept which places primary responsibility not on the medical corps but on the military personnel themselves.

The promotion and maintenance of mental health was a responsibility of the company commander, the first sergeant, the platoon leader, the squad leader, the soldier's buddy and the soldier himself. My most important function as the psychiatrist was to advise and to educate as to how to maintain health. Any case of mental illness sent to the hospital was considered evidence of failure of our health program. Furthermore, it was shown over and over again in combat psychiatry that the nearer to his own unit a psychiatric casualty was treated, the better his chances of being re-

stored to useful function. This was a consistent observation in all theaters. The best-equipped, best-staffed, base hospitals, far in the rear, always had the poorest results in treating psychiatric casualties. The reasons for this were doubtless highly complex, but one can confidently draw one lesson from this experience. Medical skill alone may be ineffective in treating mental health problems if it is given in a cultural setting which has unhealthy connotations. At the same time even rather amateurish, hit-or-miss, medical attention may achieve excellent results when given in a setting which permits the continuing operation of all the emotional forces which keep us operating well in our home communities.

The National Mental Health Act has provided funds to the states for community mental health services since World War II and results have been rather interesting. The funds from this source have never been large enough to support more than a fraction of needed service in any state, but it was hoped that they would act as pump-priming stimulants to local developments. In some states these federal funds have been used to support state-operated outpatient services, with the clinic personnel drawing their support, their policies, and their instructions from the state capital rather than from the people they serve. It is probably safe to generalize that, by and large, where federal funds have been used in this manner, people have accepted the service with varying degrees of gratitude, but have not been stimulated to move forward in developing more adequate services of their own. In many other states, including New York, the federal funds have been used for the most part to help locally sponsored voluntary organizations develop pilot demonstrations in mental health. We have been impressed with the success of this, as the great majority of communities which have been helped in this way have developed a keen local interest in developing and supporting still more service for their people.

Perhaps the most significant event has been our experience with the Community Mental Health Services Act. In 1949 the New York State government became convinced that it was a losing game to try to stem the tide of mental illness by concentrating all of our efforts on the state hospitals. It seemed that the more money that was appropriated, the better the treatment results, the greater the

number of patients came to the hospital, and the larger the bill was the next year. It was apparent that we had to find an entirely new approach of a preventive nature; and the interdepartmental mental health commission was established to make studies and develop a master plan. After a great deal of work, the commission came up with proposed legislation, which was passed unanimously by the legislature in 1954.

This act of 1954 establishes a permanent system of state aid to localities for community mental health services. No community is required to do anything, but the counties and larger cities which elect to do so and which take certain prescribed organizational steps will receive, from the state, a 50 per cent reimbursement of their expenditures. Note well, however, that the initiative and all operating responsibility remain with local government, with the state paying half the cost and prescribing minimum standards but allowing maximum freedom of choice to local communities within the limits set by the law and the regulations. The success of this whole program has exceeded our most optimistic expectations. New York City and 13 other counties are already fully operating the reimbursed services, and these communities include 72 per cent of the state's population. Eight other counties, with another 10 per cent of the population, have passed local laws and are in the process of formulating programs.

In 30 additional counties officials of local government or organized citizen groups have been studying the program and arousing citizen support. Altogether, 98 per cent of the state's population has shown some level of organized interest in such a program. The expansion of services has been so rapid that it has caused acute problems of recruitment of personnel, but this does not seem to discourage anyone. We have been tremendously impressed by the phenomenal ground swell of citizen interest and citizen readiness to assume responsibility, to take initiative, and to pay the cost of improved and expanded mental health services. We are completely convinced that the most important single element in the success of this program is the fact that local people are given local responsibility and that they respond to this by accepting responsibility in a way which they never will display when mental health is the state's problem.

The final and complete destruction of my preconception was ac-

complished a year ago when I spent six weeks touring mental health facilities in Great Britain and the Netherlands on a fellowship from the World Health Organization. In Britain I saw some public mental hospitals which are far in advance of the best American state hospitals. Some of these British public hospitals have such an excellent therapeutic culture that they are able to operate without a single locked door or barred window although they have precisely the same kind of patients as our American state hospitals.

I visited three of these "open" hospitals, but will describe in some detail just one of them, the Mapperly Hospital in Nottingham.

Nottingham is somewhat comparable to Rochester, N. Y., as it is an industrial city in the midlands, with a population of about 300,000. Mapperly Hospital differs from Rochester State Hospital, however, in that its "catchment area" is limited to the one city with its contiguous suburbs, whereas Rochester State Hospital serves six counties. Partly because of this, there is a great difference in the size of the two hospitals, Mapperly having only 1,000 patients, as against 3,600 in Rochester. The most striking difference, however, is in the functions carried out. The Mapperly Hospital is the only mental health facility in its area, and it is responsible for all types of mental health service, both inpatient and outpatient. In fact the staff is an all-purpose community mental health staff, which is identified with the *hospital* for payroll purposes only. All physicians spend at least one-third of their time in the community, and senior staff members as much as half of their time.

Perhaps the best way to visualize the Mapperly functions is to trace what may happen with an individual patient. A person thought to be in need of psychiatric care is called to the attention of the hospital, usually by telephone, and usually by the family physician. The patient is then visited in the home, usually by a social worker, who calls in a hospital physician if the case is at all complicated. The psychiatrist holds what is in effect a consultation with the family physician and offers his recommendations as to the next step. He may advise the physician and family as to how to handle the case in the home, and may arrange for visiting nurse or social services as indicated. Or arrangements

may be made to place the patient in a nursing home. Or the psychiatrist may refer the patient to an outpatient clinic, adult or child guidance. The patient may be admitted to an inpatient service in a general hospital for short term study and treatment; and there is such a general hospital unit for children as well as one for adults. There is a day care center for the ambulatory, aged mentally ill; and, in a general chronic disease hospital, there is a unit of four wards for infirm aged mentally ill. And finally, there is the mental hospital itself. All of these services are supervised by the same staff, and the mental hospital is just one of the treatment methods this staff has to offer to some patients during some stages of their illnesses. The same flexible battery of services is, of course, available to the patient on his way back to health.

Under this system it can often happen that, at different times in his illness, the patient will be treated by the same doctor, at home, in clinic, in general hospital, or in mental hospital. This is thought to be one of the major factors in facilitating the open hospital and the high rate of voluntary admissions. Of the admissions to Mapperly, 90 per cent are voluntary, and patients are said to arrive with a trusting attitude because they are not being sent away to a strange place, but are only undergoing a somewhat different treatment plan by their own doctor.

This Nottingham arrangement is one of the finest examples I have seen of the so-called "swinging doors" policy, which we all talk about these days. There are also swinging doors in the Mapperly Hospital, quite literally. The hospital was part way through an extensive remodeling when I was there. New ward doors had been installed, on which the only hardware was the hinges. There were no locks, no bolts, no latches even.

In the British National Health Service, there is one door which does not swing freely. Officially there is a sharp division between hospital authorities and local health authorities. The hospitals are responsible only for inpatients, and for their own outpatient clinics. All other community care, whether before or after hospitalization, is the job of the medical officer of health. Most officials deplore this division, and struggle to find ways around it. How did they get around it in Nottingham? First, these relationships and functions were developed before the British government stepped in, when Mapperly was a *locally* operated hospital. Prior

to 1948 there was only one national mental hospital in Great Britain, the institution for criminals at Broadmoor. All the other public mental hospitals were operated by counties and county boroughs.

In Nottingham, on the recommendation of the health officer, the borough council named the superintendent of Mapperly as "mental health officer" to give him legal responsibility for health as well as sickness. This became illegal under the 1948 National Health Service Act, but a way around it was found. The health officer has designated one of his deputies as "mental health officer" and has arranged that this man and his staff work under the professional supervision of the hospital staff. There are seven "duly authorized officers," who have certain statutory duties with regard to institutional placement, and these positions have been filled entirely with psychiatric social workers. These seven, and the four on the hospital payroll, all work out of one headquarters, use one set of files, and do much the same sort of work.

To date, therefore, the national authorities have not stopped local initiative from circumventing national policies of which there is local disapproval. Despite the complete nationalization of medical care, I was struck by the fact that London exercises much less detailed supervision over its public mental hospitals than Albany does over its. Of course, the British have had only eight years of central authority, but non-interference seems to be a conscious and deliberate policy on the part of the Ministry of Health. The ministry recognizes that the relative lack of supervision from London permits some hospitals to lag far behind, and there are some very poor hospitals in Britain. The authorities believe, however, that significant advances, which show the way for all of us, can be made only where there is freedom from bureaucracy and the maximum encouragement of individual initiative. They, therefore, confine their functions to broad statements of policy and leave all working details to local institutions. Each institution also has a local management committee representing the local citizens; and, at least to date, the old feelings of local pride and identification have not been destroyed by the fact that the nation is paying the bill.

In the Netherlands, there is an entirely different system, but some of the same principles of human motivation are involved. In

that country there are no state-operated mental health facilities. There are a few municipally-operated hospitals and clinic services; but the great majority of mental health services for both inpatients and outpatients are maintained by voluntary organizations, many of them religious bodies. The Netherlands is quite definitely a welfare state, in which the government guarantees employment, housing and medical care to all its citizens and has done so for at least 50 years. It is striking, though, that the government, while paying much of the bill, delegates so much of the operating responsibility to private voluntary organizations. Another significant factor in the Dutch scene is that municipalities must pay a large part of the cost of hospitalizing their mentally ill regardless of whether hospitalization is in a municipal hospital or in one of the publicly-financed but privately-operated institutions.

This local cost factor was the principal motivation for the establishment of the city of Amsterdam's mental health service which has become world famous. The city fathers were concerned with the way their budget was being wrecked by hospital bills and determined that they must set up community services aimed at cutting down the number of patients who had to be in the hospital. The first step was to set up adequate aftercare services, and this made it possible to release a substantial number of already hospitalized patients. The authorities then turned their attention to what the Dutch call pre-care. By agreement of the municipality and of the companies which provide hospitalization insurance, no patient can be admitted from the city to a mental hospital without first being referred to the city's mental health service. This service has teams of psychiatrists and social workers all over the city, on call 24 hours a day, seven days a week. Anyone thought to be in need of care must be referred to them and they promptly swing into action. Some cases they are able to treat in the home. Others are referred to outpatient clinics or placed in the University Hospital for temporary observation, or placed in a boarding home or nursing home. By thus thinking of and using a whole variety of services in a discriminating way, instead of automatically sending every mentally ill person to the mental hospital, they have managed to reduce sharply the number going to institutions —and to claim a net savings in total cost.

The one overwhelming lesson to me from all these experiences

is that it is high time that mental health joined the do-it-yourself movement. Mental health services provided to a local community are likely to be effective in proportion to the degree that they are initiated locally, managed locally, and at least to some extent, paid for locally. This has serious implications both for outpatient and for inpatient services. For purely outpatient services, there is pretty general agreement on the value of local sponsorship as against state operation, even though there are still some states in which virtually all clinic service is provided by the state. Rochester, for example, has for a long time been well in advance of most cities in providing a variety of services important to mental health. It is safe to assume that its leaders are far from satisfied with what has been accomplished so far, and have big plans for the future. With some hesitation, however, I would like to venture a step further and suggest that even the ideal goals presently imagined for such operations are unnecessarily restricted, and that there may some day be much wider horizons of usefulness than we now dare dream of. I am nagged by a growing fear that much of our best community effort in mental health has been misdirected or at least too narrowly directed. I am not for a moment minimizing the extremely valuable work that is being done by many agencies. However, many first-rate community mental health services tend to erect a wall which excludes those citizens most in need of help, those with serious mental illness.

Let me give a couple of examples of the kind of thinking behind this. One of our New York state hospitals has a unit for mentally sick children, most of whom come from one city. Some of these children have no homes to go back to when they get better, so it is necessary to find foster homes for them. This has always been difficult, and the problem has long been a matter of negotiation between the hospital and the city. These negotiations recently broke down when the responsibile city official wrote a letter, in effect saying: "We have enough trouble finding foster homes for our own children, without taking on the responsibility for the *state's* children." Apparently children automatically lose their local citizenship when they are deported to a state facility.

Here is another example. In one county in the state there are no psychiatric clinic services, but there is an active citizen movement for their establishment. One small group of physicians has

opposed this on the ground that they see no problems in their practice that they cannot take care of themselves, and they see no need for a clinic. I confronted them with the unpleasant fact that their county has the highest admission rate to the state hospital in the entire state outside of New York City. They brushed this aside as totally irrelevant on the grounds that the "insane" belong in the state hospital anyway and that this has nothing to do with the number of people who need mental hygiene services and are not "insane." Many psychiatrists who devote themselves exclusively to non-psychotic patients sincerely believe that they are preventing psychosis by concentrating on non-psychotic psychiatric problems. Regardless of how much help this gives to troubled individuals, there is a growing doubt as to how much it accomplishes in preventing major illness, and a growing conviction among some of us that community psychiatry must be lured away from its comfortable practice with neurotics to do more for the mentally ill at home.

I am sure that the fault, if there be fault, is not in people but is in our whole system, which invites and almost forces people to act as they do. What practical motivation is there for local officials to struggle endlessly to help a mentally ill person at home when they can so easily get out from under the whole problem by sending him to the state hospital? In our state, commitment to the state hospital gets this troublesome problem off the local relief rolls, off the busy local clinic schedule, out of everyone's hair and all for free—and people like me go around telling you that, in thus dumping your problems on the state hospital, you are only performing your painful duty of getting the poor unfortunate under treatment. Please do not misunderstand me; for a great many of the patients, the state hospital is the best treatment available and one which should be used and which is often successful. Furthermore, virtually every patient sent to a state hospital is ill and in need of treatment. The question I wish to raise is whether the purely medical indications might not call for community, rather than hospital treatment for some of these cases, if the right kind of community facilities and attitudes were available. Also is it not altogether probable that in some cases the decision to hospitalize a given patient is made for economic or other reasons quite irrelevant to the patient's treatment needs?

There is never going to be any easy answer to all these questions. Our present system of total state responsibility for the mentally ill acts as a powerful barrier to the development of the local feelings of responsibility which are essential to the development of good local programs. It would be most difficult to change the state's responsibility in this area, because our whole history and our present tax structure almost mandate the present system. Is it not conceivable, however, that if we become sufficiently convinced of the human necessity for a change in our structure, we may overcome the technical difficulties of revising tax structure and our whole system of governmental responsibility? There may be such essential values in the motivation found in the Dutch system, in which local government must pay much of the cost of hospitalizing the mentally ill, that we will find it necessary to overhaul our entire structure in that direction. Certainly I do not advocate that the state should take an irresponsible attitude toward its unfortunate citizens. It seems to me, however, that some day in the future the state will find that it can much more effectively discharge its responsibility by delegating many operating responsibilities back to local communities.

Probably no one foresaw one tragic result of the State Care Act of 1890. The state, by accepting total responsibility for the mentally ill, licensed everyone else to be totally irresponsible. For too long a time with mental illness, it has been possible to discharge your obligations to your brother completely, to feel that you are your brother's keeper, just by paying state taxes. That is not enough. We must search for ways of reorganizing our whole system to take advantage consciously of the natural goodness of people, their innate desire to be their brother's keeper in the home, the neighborhood, the city and county.

I hope I have been able to convey the idea that my championship of community responsibility is not based on fear of creeping socialism or belief in state rights or free enterprise. It is just my conviction that we will never get good mental health if we let George do it. To get good mental health, we must live it, work at it, share in it, and make our schools, our churches, our playgrounds, our factories, our whole community, healthy places in which to be and to live.

Even as matters are, I am happy to see so many people on the mental health bandwagon. Twenty-five years ago, this wagon was rather empty, and it used to get pretty lonely at times. Now it is crowded, and it sometimes becomes extra crowded on the driver's seat—with some of the newcomers trying to take over the reins. Perhaps the jostling will help to get the wagon out of its ruts, however, and it is greatly encouraging to have so many aboard.

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EDITORIAL COMMENT

"HE SOLVED THE DARK ENIGMA . . ."*

Sigmund Freud was born on May 6, 1856 in the little town of Freiberg in Moravia, crownland of the glittering throne from which the Hapsburgs ruled the baroque Austro-Hungarian Empire. This year, we observe his hundredth birthday anniversary. Never has there been such a century in the annals of man.

We did not always see it so. Those of us whose childhood memories are of late Edwardian or Victorian days lived then in a comfortable, unexciting and unpoetic world from which romance had disappeared with the fading of the American Wild West and the exploration of the last of Africa's steaming jungles. Because life seemed stodgy, there was a well-known parlor game, played by their elders as well as by children: "If you could have chosen, where and in what period of the world's history would you have liked to be born?" And this was by no means foolery with a daydream; it was a question asked seriously and answered seriously; it was a legitimate subject for debate; it was frequently considered educational; and it must have been the source of volumes of schoolboy and schoolgirl essays.

If this was so, it was because the civilized world, as seen from an American small town or a French fishing port or a suburb of dingy London, center of an empire from which most adventure had vanished, seemed dull and colorless. Perhaps it seemed so too even in gay and spirited imperial Vienna where Freud spent his youth and young manhood; and perhaps Freud, like many more of us, played the "if you could choose" game. At least, like many another, he was fascinated by favorite characters in history, Moses, Hannibal and Napoleon's great marshal, Masséna, choices reflected in his work and his writings in his later life.

"If you could choose?" Would you have been a philosopher-companion of Confucius, a captain of horse with Alexander in Persia, a governor of a province when Rome was great, a companion of

*From Sophocles' *Oedipus Tyrannus.* Quoted in an inscription on a medallion presented to Freud on his fiftieth birthday. The obverse showed a profile of Freud's head; the reverse, Oedipus and the Sphinx, with the legend in Greek which may be translated somewhat freely as, "He solved the dark enigma and was a man most mighty."

Pericles, or a leader of the great Italian Renaissance of art and learning? Or would you have sailed uncharted seas with Columbus, or with Leif, red Eric's son, or served a gun with Hawkins or Drake, or consorted as playwright and poet with Jonson, Marlowe and Shakespeare in the great days of the first Elizabeth? Or, if you were a girl, would you have liked to be Elizabeth I herself, or Aspasia, or Lady Hamilton, or Martha Washington, or Florence Nightingale?

The time has passed—within the lives of most of us—when other days and other characters seemed more exciting than our own. The culture of the Western World now blazes like a nova. If we now read historical fiction, we read for painless education or vicarious adventure; we used also to read—in Scott, Thackery, Kingsley, Bulwer-Lytton, Sienkiewicz, America's Winston Churchill, Cooper, Lew Wallace, Baroness Orczy, Dickens, Sabatini, and Conan Doyle—for transport to more exciting worlds than ours, for life in more exotic climes, and for the witnessing of more heroic deeds and gaudier displays of genius than could be found in our own places and in our own times. We have scriptural warrant that there once were "giants in the earth"; we understand them to have been giants of the sword, the pen and the pure intellect—and to have lived in the midst of tremendous, fate-laden crises in human affairs.

Could Hannibal have taken Rome if the dreamer over history could have added his own arm and his sword to the might of Carthage; could a strong and fearless counselor have upheld Atahualpa and saved Cuzco from the destroyer? Could companionship with Dante and Petrarch have taught one the secret of immortal verse; could one have learned from Descartes the art of reasoning; from Voltaire, the wit to destroy shams; from Galileo and Newton the power to descry the secrets of the universe? Those were brave dreams, if adolescent. There are brave dreams today among the adolescent, but dreams more often in a new and different sector of our space-time continuum, not a sector of an old world in time past, but a sector of a new universe in time future. For the giants of our own day have come—and many have gone—and have towered so hugely over the giants of the past that there is little recourse in the past for great dreams anymore; one must do

any such dreaming in speculation about a possibly glorious but still doubtful science-fiction future.

The hundred years that began in 1856, Freud's century, are unlike any other hundred since human records began. If energy, intellect and high achievement poured in flood in the great days of Athens or in the England of the Elizabethans, they have erupted volcanically in our own times. If the Italian Renaissance was the re-birth of the Mediterranean civilization, our own times have seen, not a similar re-birth, but a vast mutation, affecting the whole structure and function of the western world. Aristotle or Plato could not have companied with Einstein, Bertrand Russell or Darwin. And there would be lack of proportion if one were to range the traditionally great military leaders and statesmen of Europe, Alexander, Caesar, Napoleon, beside Churchill, Roosevelt, Stalin, Hitler, who—whether good and great, mad, or simply evil —are collossi reaching to the clouds, the whole world for their arena.

The hundred years since 1856 have seen an upsurge and a broadening of the stream of scientific and technological developments of which older generations would never have been able to conceive. In 1856 coal industrialization had not reached the peak of its development; the possibilities of electricity for power, for light and for communication had scarcely been glimpsed. The internal combustion engine was still impractical, the jet and rocket engines unknown. The automobile, the telephone, the radio, all sorts of electronic developments from radar to television were far in the distance. Edison had not yet invented the graphophone or Marconi wireless telegraphy. The Wright brothers and the airplane were 49 years away, the Manhattan Project's great pool of scientists and the atomic bomb, 89.

When Freud was born, Darwin's great work, *On the Origin of Species,* the foundation of the whole of modern biological science, had not yet been published, and understanding of the mechanism of heredity was many years away. In medical science, Joseph Lister, the father of modern surgery, had still to announce the researches which were to conquer postsurgical infections and postsurgical hemorrhage. Freud was nine years old when the first of the two Lister techniques, which were to bring surgery from the medieval to today's world, was made known. The thin trickle of

scientific and technical advance had begun; but Freud was to be half a century old, his own epoch-making achievements well-grounded, before it became apparent that he was living in the midst of intellectual, scientific and technological advances which were coming in a tide beyond all previous human imagination. And even then it must have seemed merely that man had learned a few new tricks, that science had provided a few new comforts and new toys but that there was still more theoretical advance than really material change in human affairs, and that, after all, horse-and-buggy man was likely to go on living his horse-and-buggy life, perhaps more comfortably, but essentially pretty much in the way his great-grandparents had lived before him.

In the year of Freud's birth, Europe had but half-emerged from political medievalism. In Austria itself, Francis Joseph was enjoying a few years of short-lived absolutism. Weak kingdoms and petty despots, leaning uncomfortably on Austrian bayonets divided unhappy Italy. To the west and north of Austria, the Germanies were still a congeries of half-impotent independent states, trembling before the growing might of Prussia. In France, Louis Napoleon Bonaparte held state in an ill-fated revival of a conqueror's once-great empire. In London, Victoria, not yet empress of India, but queen of England, Ireland and Scotland, reigned over a land where social conscience and enlightened self-interest were at last overcoming the worst cruelties and excesses of the industrial revolution. In London exile, a German reformer and revolutionary—who had once raised the cry, "Workers of the world, unite; you have nothing to lose but your chains"—brooded over the ills of society and the encyclopedic work he planned for their remedy. When Freud was 11 years old, Karl Marx published *Das Kapital.*

In nearby Rhenish Prussia, Neanderthal man was discovered; and in the far-off United States, the Republican Party was founded, the year Freud was born. Abraham Lincoln was still a somewhat obscure politician. The gilded façade of a civilization based on the traditions of chivalry still rose in the South above a foundation of slavery. Still to come, were the glamour and bloodshed of the Civil War, the boisterous winning of the West, the slow industrialization and the rise to world power of the American nation. Undreamed of, was the dramatic twentieth-century shift of

intellectual and scientific leadership (including leadership in psychiatry) from Europe to America.

The world's transformation has been both spectacular and inclusive. There has been more material and scientific advance in the last hundred years than in all the centuries between the great culture of Alexandria and the year 1856. Caesar would have recognized the paved streets and stone structures of a century ago, and he might have reflected that in his time they at least built roads better; but he would be baffled by 1956's thousands of miles of asphalt highways. He would have approved 1856 highway transportation as showing laudable improvement in carriage making; and he would likely have wondered that his own day had not put the toy steam engine of the Alexandrian experimenters to the practical uses he could see on all sides; but a concept of today's jet airplanes would have been utterly foreign to the ancient Roman mind. So, a century ago, Caesar would have observed improvements in lighting; whale oil lamps with glass chimneys were an obvious advance over the Roman open dish with flaring wicks, though fundamentally the same thing; but today's fluorescent lighting employs, not an improvement, but a principle completely unknown to the ancients.

There has been an even wider break with the past in the science of man in the last hundred years than in other sciences. Thousands of earnest workers, from medicine to philosophy to education, contributed to the transformation; but the movement was led by half a dozen towering figures—such men as Darwin, Lister, Pasteur, even (with whatever great reservations) Karl Marx.

The nature of man has been contemplated and pondered upon as far in the past as we have records of intellectual activities. Widely varying concepts of what is man, why is man, and how does man differ from the non-human have been at the base of all our great philosophies and all our great religious systems from long-forgotten tales of creation by the long-dead gods of Egypt and Sumer to Descartes' *"Cogito, ergo sum."* Medicine from the most ancient times studied human ills and the conditions of human health. The philosophies and the religions laid down the conditions of the good life, set forth the purpose of life, regulated the conduct of life. All this, they did by religious fiat and philosophical hypothesis; of inquiry, by methods we would recognize as scientific, there was none.

For one reason, there was no such inquiry because study in which the observer is also the thing observed is as difficult a labor as the mind of man can conceive. Two and a half millennia ago, somebody asked the great Thales of Miletus to name a difficult task. "Knowing one's self," was his reply. If Thales' opinion of the obstacles was well-founded, man's failure to know himself has not been for lack of interest, intellect and application. It has been in the nature of the material of man himself, and in pre-accepted philosophical or religious ideas concerning him, and lack of scientific method for studying him. The dichotomy of soul and body is an unthinkably ancient belief, far antedating Christianity or Judaism. It was accepted uncritically by classical Rome and Greece—and elsewhere all over the civilized and uncivilized world. When man sat down to study himself, whether he was an Athenian philosopher, an early Christian anchorite, or a medieval scholar he did so in this unquestioned and unquestionable framework. The most serious, intense and devoted study, pursued by the finest intellect, was bounded by this mistaken limitation.

The human mind was limited also in its study of itself by another mistaken assumption—that it was the sum of the intellectual and emotional functions that it appeared to be, that the boundaries of which man was conscious were the boundaries in fact, that the small parts of the mind we now label "ego," and "consciousness" and "intellect" were the whole of it. There was fine study of man's mind within these limitations; the development of the science or art of logic was based on adequate appreciation of the ego's workings. Francis Bacon, discussing the difficulties of clear reasoning three centuries ago, laid down his principles so admirably that they may be applied today without qualification or emendation. As quoted in a recent textbook on logic and language,* Bacon's remarks, in tenor and application, could have come straight from the work of a modern General Semanticist.

But the obvious limits of the subject—and the lack of a reliable investigative instrument—remained. If Freud burst those boundaries and provided, in the psychoanalytic technique, the objective instrument needed for inquiry, he must not be thought of either as a shaggy-haired medical anarchist with a bomb, or a

*Huppe, Bernard F., and Kaminsky, Jack: Logic and Language. Knopf. New York. 1956.

psychiatric Archimedes, running half-clad through the Vienna streets and shouting, "Ενρηκα." Freud's personal activities were neither explosive nor sudden. From neurohistology, to neuropathology to the neuroses, Freud pursued an unremarkable path to a remarkable destination. As the author of his standard biography points out,* Freud was more interested in man as the subject of study than in medicine as a science; he might very well have become a lawyer or have engaged in some other branch of social science than the medical. As Jones remarks,** his interest in psychological problems dated at least as far back as his days as a medical student. Why and how this interest persisted and developed through years of medical research is something better discussed in detail elsewhere. Along broad lines, it is permitted to conclude that Freud felt the need of the painful personal inquiry through which he developed psychoanalysis. It is certain that he relieved severe personal neurotic trends thereby; and some of his most fervent admirers are inclined to think "neurotic" may be an understatement.

When the greatest of Freud's contemporaries pursued their work in such disciplines as biology, chemistry, surgery, immunology and physics, they built on already well-prepared foundations. Revolutionary as their theories proved, Darwin and Wallace had been preceded by Lamarck, who saw and recorded the same evolutionary processes they did and failed only in the matter of mechanism. Pasteur's genius is undoubted, but his discoveries were the logical continuation of the work of generations of chemists, physicists and microscopists. Lister and antisepsis—and later asepsis—were directly related to the work of Pasteur. So was the work of the early epidemiologists and immunologists. The great wave of invention from Edison to the Wright brothers represented the practical application of knowledge developed by many others, some of it long before. Einstein and the brilliant school of modern mathematicians and physicists rebuilt the foundations of the modern world; but they rebuilt foundations laid by Newton centuries ago, employing and modifying Newtonian concepts. Even Mendel in genetics was not working with entirely new material;

*Jones, Ernest: The Life and Work of Sigmund Freud, Vol. I, 1856-1900. Basic Books. New York. 1953.

**Jones, Ernest: Ibid.

he applied the scientific method to observation and measurement of familiar phenomena and devised a brilliant hypothesis to account for his observations.

However led or driven to it, Freud explored virtually unknown territory. The dream had been a mystery from immemorial time. Dreams had been observed, recorded, studied, interpreted—sometimes with intuitive accuracy. But their nature, function and meaning were not at all understood. Explanations were, in general, as wide of the mark as the ancient theories which conceived of the stars as lights set in crystal spheres to illumine an earth which was the center of a tiny universe. Freud not only gave the dream its place in man's psychic economy, but devised a scientific method for its understanding.

So it was with the magnificient Freudian concept of the unconscious! Freud was not the first in medical annals to perceive the existence of this vast and still largely uncharted territory; its importance is implicit in some earlier scientific writing; it is even explicit on occasion; Breuer appears to have used the term. But Freud was the first in the history of science to understand and explore.

The understanding of the mind which was reached by Freud was —unlike Pasteur's contribution to microbiology—not a logical development from what had gone before. If Pasteur, Lister and the early bacteriologists had never pursued their researches, others would have made their discoveries in time; results would have been assured by the orderly progress of orderly scientific research. There is no such assurance that either the existence of the unconscious would have been generally accepted, or its study pursued successfully if Freud had never made his inquiries. Freud was led thereto by the needs of his patients and himself, as well as by intellectual curiosity. Why he was able to follow the lead and how he was able to do so successfully are questions that can by no means be fully answered, even by applying Freudian methods of investigation to Freud's own life. That he went further, more daringly, and at the cost of more pain, than ever characterized any other similar research, are matters no modern student of psychology can doubt. Freud was his own cat in the laboratory maze, his own experimental dog, his own guinea pig. He worked with his own reactions, studied his own weaknesses.

Today's generally-accepted concept of the human mind and emotions—in sum, the human psyche—we owe to Freud. Freud mapped the mind as the limited land of the conscious and the great wilderness of the vaster unconscious, with the half-perceived borderland of the subconscious between. He identified, and in some sense measured, the dynamic forces boiling and churning in the undermind. As in quantum physics, a quantum may be thought of both as a wave and a particle, so in Freudian psychology, the mind may be thought of both as a place and as a functioning apparatus. In this mental machine, fueled by the energies of the body, modified by pressures and materials from the environment, great streams of instinct for pleasure and for destruction whirl through the animal-primitive mental chamber we call the id. Channeled, repressed, modified beyond recognition by other mental forces, which seem to be man's peculiar, and magnificent, achievement and which keep the beast in us from ordinary perception, the primitive strivings emerge as consciously-felt thoughts, emotions, ambitions aspirations, daydreams, to form the conscious that we recognize as the self, the ego, or the "I." Or thwarted, the instincts force their way into abnormal paths toward mental and physical symptoms—symptoms that are to be relieved by painstaking processes of tracing backward to the source, freeing from distortion and re-directing into useful or harmless activities.

For the inaccuracies, the distortions, the omissions, the deletions, the elisions involved in such a sketch as this, one can only pray that all practising analysts, and the understanding spirit of Freud himself, will extend forgiveness. The Lord's prayer may be engraved successfully on the head of a pin; the bounds and conditions of a great new science can stand no such compression. But scientific exactitude imports less in this discussion than the adequate presenting of the contrast between the old and the new views of man's mental activities.

A century ago, man was made up of the ego, which was the self or the "I," and the body that the ego or the "I" inhabited. The "I" was also the man himself, the whole of his non-physical, plus his physical, nature. Or the "I" might be thought of as a soul, or as a mind and soul; the spirit was, in any case, separate from the body it lived in; there was no mystery about it, unless in point of its religious or fortuitous origin; the "spirit-I" supposed it

knew all of itself and all about itself; its boundaries were consciousness; its body was its possession. One can note, too, of course, that if this sketch is truthful in the main, violence has been done here also to various concepts and various qualifications held by one or another religious or philosophical school to be fundamental tenets.

In the old psychology, however, all of man's mind was generally agreed to be an easily discernible, if not tangible or even comprehensible, thing; in the light of Freud's inquiries, little of it is easily discernible, some of it is not yet discernible at all, and all of it is a churning turmoil. It can be investigated only in most cautious fashion, with the most delicate techniques, such as free association. The investigation—like that in sub-atomic physics where, if one is certain of a particle's position, one cannot be certain of its velocity, or where, if one is certain of a particle's velocity, one cannot be certain of its position—meets a multitude of indeterminacies. As in sub-atomic physics, the investigating instrument affects the state of what is investigated. In the sphere of the human mind, as in cosmology, we have lost false certainties, to replace them with true, if not understood, uncertainties.

In another frame of comparison, the dichotomy of soul and body is gone. The religious concept has no bearing here; its validity for religion is not necessarily in question; whatever the mind we study may be, it is not what theologians call the soul; and the soul's existence is another matter. The mind, the psyche in the modern sense, can no longer be considered separately from its body. It is neither a resident nor an owner. One of the most useful of the new concepts which Freud's research has made necessary is that of mind as a function; and it may be admitted that there is no satisfactory definition of function to serve here. Or one may also conceive of the mind as in some sort an organ or limb. The only thing we can be certain of is that there is no profit in medicine or psychology in considering mind as a separate entity. For medicine and psychology, body and mind cannot be divided; even in the medical specialties, there is no valid and certain separation. The "mental" disorder of hysteria concerns bodily functions. The specialty of "psychosomatic medicine" involves the interaction of forces that cannot be assigned to one side or the other;

and its name indicates the so-far-unsolvable difficulty of finding a descriptive term for the unity we now see.

In the last hundred years, in the general physical sciences, we have advanced with the most extraordinary strides. A hundred years ago, astronomy started at the sun and planets and probed tentatively toward the milky way, the boundary of our own star-system. Today, a modern journal can devote an entire issue to astronomical advances, starting with a point then hardly reached —the galaxy—and extending to a billion other galaxies.* But between the astronomy of then and now, there is a firm continuity; there has been merely a widening of the field through improvement in method and advance in theory.

Between the psychology and psychiatry of a hundred years ago and the psychology and psychiatry of today, there is—as has already been remarked—no such continuity; we have retained some of the past, it is true, but in the form of a few threads—and those slender ones. It is almost as if Freud had found man a fresh subject of study in a new Garden of Eden—and this time not a garden of celestial innocence. And because of this, one may wonder if any man in the world's history has played a comparable role or exercised comparable influence. The whole field of dynamic psychology has been revolutionized; the habits of thinking of all literate mankind have been changed. The suggestion may not seem fantastic to the well-informed that in time, Freud may tower as a scientific figure, even above Einstein, and that he will occupy as high a place as any in all the ages of the benefactors of mankind.

Freud brought new concepts and new techniques to psychiatric therapy which have revolutionized the theories and the clinical procedures of a discipline—modifying the ideas and practices of even his bitterest opponents. But aside from the revolutions he brought in the concepts and conduct of psychotherapy, he stands as one of the world's greatest discoverers and explorers. In the centuries of human history, there have been a few great individuals who looked beyond what any fool could see was plainly so and discerned truths that were not apparent—truths that might be in plain contradiction to common sense and common observation. Such men were Aristotle, who advanced the first scientific evidence that the earth was a sphere; Eratosthenes, who actually measured

*Scientific American, 195:3,72-236, and bibliography, 278-282, September 1956.

it—and with fair accuracy; and Columbus, whose westward voyages first convinced the common man of Europe of its truth. Aristotle and Eratosthenes had predecessors who believed the earth was a sphere on philosophical grounds and had guessed at its size on the basis of their philosophies; Columbus had a predecessor in Leif Eric's son who had crossed the western ocean nearly five centuries before—but with no suspicion that he had sailed over Ginnungagap, from the lands shaped by the gods from the body of the slain giant Ymir, to a new face of a new world.

Like cosmologist and seafarer, Freud had his predecessors into the unknown. Shakespeare, for one among many, had uncanny insight into mental and emotional mechanisms which it remained for Freud to identify and delineate. As has already been said, others than Freud had postulated the existence of what we now know as the unconscious; his biographer, Ernest Jones, cites Wilkes and Lipp.* But it was Freud who gave scientific proof to displace speculation, Freud who entered and mapped the unknown territory, Freud who painfully developed the free-association technique which made real explorations possible. It was Freud, too, who embarked on his inquiries with firm insistence on understanding the unknown in the light of the known, of interpreting the new within the framework of medical facts, and of insisting on the existence of a still-undetermined relationship between structure and function—without which structure and function alike fail of complete meaning. If we can accept without horror today the prowling of primitive lusts and hates through the unconscious, it is because Freud proceeded, cautious step by cautious step, to explore a thing—even today still largely unknown—as dangerous and unpleasant as the fever-ridden jungles of the Congo. One need not be concerned at this point with the complete accuracy of his reports of this unknown territory, though his principal landmarks still stand immovable, or with how correctly in detail he assessed the nature and strength of the beastly forces he found therein. He had brilliant pupils, and he stimulated independent minds to repeat his own experiments and do their own independent research.

In the last half-century, there has been continued exploration in the unknown continent that he discovered. Some of it has followed the general lines of his original endeavors, as in the study of the

*Jones, Ernest: Op. cit., Vol. 1, p. 397.

ego and its boundaries and in the development of super-ego theories. Some has diverged; some has wandered away altogether. And clinical use of Freud's discoveries has sometimes followed his own methods, sometimes diverged, sometimes gone beyond, as in hypnoanalysis, in group psychotherapy, and in such departures as the treatment of psychoses by psychoanalysis—the last first undertaken during Freud's own lifetime and despite his skepticism, by his pupil, Paul Federn.* (THE PSYCHIATRIC QUARTERLY published Federn's dramatic account of this, the first such report in English, in January, April and July 1943.**)

As this discussion has not been concerned with the details of divergence in theory and practice from Freud's own conclusions and methods, it is not concerned with the validity of dissidence or divergence or with the personalities of the dissidents and seceders. One could assume that Adler was right in his rejection of sexuality, that Jung was right in his mysticism, that Rank was right, that Horney was right, even that Wilhelm Reich was right —and Freud's stature would not be reduced a millimeter. Freud pioneered. Jung's disciples would dispute it; but virtually everybody else would agree that, however important the work of these and other individuals may be, none would or could have undertaken it without Freud's exploratory efforts.

Unless one turns to solipsism, it usually seems natural to divide scientific inquiry into the object of the inquiry and the instruments of inquiry. The human mind is the principal instrument—and will remain so until other intelligent life appears—of all inquiry. It is thus the half—or something like it—of all scientific processes. One may take any exact, observational and experimental science, such as metallurgy, with such instruments as the microscope, the spectroscope, chemical reagents, radioactive tracers, micro-measurers and weighers, electronic computers; all are tools of the human mind and worthless without it. No automation to exclude the ultimate mental process has ever been devised, and none is conceivable.

It is also only too natural, of course, in ordinary, as in scientific, life, to divide all experience into the observer and the observed,

*Federn, Paul: Ego Psychology and the Psychoses. Basic Books. New York. 1953.

**Psychoanalysis of Psychoses. Parts I, II and III. PSYCHIAT. QUART., 17: 1, 3-19; 17:2, 246-257; 17:3, 470-487, January, April and July 1943.

the "I" and the "not-I." As it is the half of scientific processes, the personality is also the half of life-processes in general. All human experience, from the observation of the "canals" of Mars to the sacrifice of babies to Moloch, is a combination of elements of the "I" and the "not-I." Sensations from the "inner" environment as well as from the outer are mediated through the "I." (And the "inner" environment concept is a convenient assumption, rather than a real entity, for the "inner" environment and the "I" are indivisibly one.) If we are to understand either the ordinary world or the world of science, we must understand something of the mediating "I."

That the mediating "I" is not the simple, conscious, readily-accessible ego it appears superficially to be, is what Freud and the exploration of the unconscious have taught us. They have taught us to take into account, in observation of—and reaction to—the world and ourselves, factors which the man of two centuries ago or the man of the Renaissance would not have believed existed. The modern scientist of any discipline tests and re-tests his results in the light of possibly unconscious errors, biases and motivations; or if he does not, he should; and the numbers of those who are aware of the need and scrupulous in observing it are growing daily.

Knowledge of the dynamics of the mind has influenced all science and revolutionized social science. The modern anthropologist would hardly recognize his colleague of a century ago. The modern sociologist disregards dynamic psychology at his peril—as the Kinsey group and other workers with the questionnaire method have found. The conclusions and the methods of general, as well as of clinical, psychology have been profoundly affected by knowledge of psychological dynamics; the IQ is no longer the end of inquiry in general psychology, and it is very far indeed from being the all. The general psychologists' modern knowledge of what they are dealing with, would, if available before, have spared us the Jukes and the Kallikaks and would have greatly modified Galton's conclusions as to genius. And today's vocational counselors try to take emotional organization into account, as well as intellectual capacity.

Like psychology, psychiatry has, of course, been changed beyond recognition in a century. Although Freud emphasized and re-

emphasized that mental phenomena have an inescapable physical basis—in fact that one cannot separate the mental and the physical —his theories were under fire for long by persons who objected to any "purely psychological" explanation of the intellect and emotions. And although he constantly stressed his supposition that there were constitutional factors in mental disorder, the psychoanalysts were under constant criticism for their "environmental" theories. The structure or function of the links between psyche and soma—or, better, of the point where psyche and soma merge —have not yet been determined. Today's psychoanalysts, though convinced of the contrary, must, as a practical matter, conduct their treatments as if mind were a purely psychological affair; today's drug therapists and psychosurgeons, must still dose and cut in ignorance of the exact psychic processes they are affecting, hoping for empirical justification by the good results of procedures that even their cleverest researchers do not entirely understand. But the practices and rationales of neither could have even been imagined a hundred years ago.

Today's analyst proceeds with full recognition that his therapy involves somatic factors. One may cite an illustrative case of deafness* with a bilateral otitis media and chronic mastoiditis—unquestionably somatic symptoms, with x-ray confirmation—cleared up during a psychoanalysis for sexual abnormalities. The analogue is the surgical operation—which may even be abdominal, not psychosurgical—that is followed by the abating of florid mental symptoms. Today's analyst is respectful of somatic substructure and its physiological functions; today's organic therapist is becoming more and more respectful of psychic superstructure and its dynamic functions. The psychiatrist administering serpasil often expects, and usually hopes, that the dynamic psychotherapist will take over the patient where the drug leaves off; the psychotherapist in his turn is not only grateful for the quieting effects of the "tranquilizers" before treatment but for the barbiturates by which un-co-coperative patients can be made accessible to inquiry as well as treatment.

Tomorrow's science can be dimly discerned or vividly imagined. But whether the prophet is a cautious researcher or an imagina-

*Foxe, Arthur N.: Psychoanalysis of a case of deafness. PSYCHIAT. QUART., 15:3, 438-449, July 1941.

tive fiction writer, psychological dynamics play an increasingly important role in tomorrow's world. More extensive and more firmly based knowledge of the human temperament is confidently expected to bring improved division of labor and more satisfactory performance of the work of the world. Possible control, use and understanding of the various psi phenomena—be they embryonic or vestigial—may come, with increasing psychoanalytic evidence that, although their mechanism is not understood, they have intelligible meaning.*

The groundwork is already being laid for space medicine; and considerations of dynamic psychology are prominent among its anticipated problems. How to keep the mind functioning normally under unknown and stressful conditions, a task for the new psychiatry, may even be medicine's major preoccupation once man is no longer earth-bound.

To appreciate the effect psychoanalysis has already had on ordinary non-scientific existence, one might take a reading course in run-of-the-mine popular fiction. A better-than-fair majority of modern novelists appear to believe they are writing psychological material. Their plots turn on Freudian mechanisms or supposedly Freudian mechanisms. The authors are wrong—generally very far wrong—much oftener than they are right; but the ideas of a great psychological structure thus conveyed are becoming widespread and are widely accepted by a multitude of readers.

The man of average education a hundred years ago viewed himself as having or being in some sense a spirit, a mind or a soul. His descendant of average education is likely to recognize that he is, or functions with, a mentality which cannot be sharply divided from the body which he also is, and that much of this mentality is a mysterious something, inaccessible to consciousness. If he has read enough—particularly of the less than half-truths of popular fiction, he may unfortunately have some very strange ideas indeed about the content of this mysterious and inaccessible something. The century's enlightenment has benefited mankind vastly but has hardly been a chemically-pure blessing. Every psychiatrist has

*Ehrenwald, Jan: Telepathy: concepts, criteria and consequences. PSYCHIAT. QUART., 30:3, 425-445, July 1956.

Booth, Gotthard: Telepathy: discussion of Ehrenwald paper. PSYCHIAT. QUART., 30:3, 445-449, July 1956.

seen iatrogenic disorders, disturbances precipitated by professional misinterpretations of psychiatric or psychoanalytic principles. With widespread half-information, we are now likely to see "polloigenic" or maybe "hoipolloigenic" (if the etymologists will look the other way), or perhaps considering the source in popular reading, "bibliogenic" disorders.

Ranged beside our scientific and social gains are possibilities for the encouragement of mental abnormality that are too plain to overlook and are enormous. Misunderstood or half-understood psychodynamics can be as dangerous as a bottle of nitroglycerine in a small boy's hands. The latest novel by one of the country's most popular writers of thrillers is a beautiful illustration.* This comment is not to be construed in reference to its psychodynamics or the plausibility of its characters or actions; but it is to be taken as enthusiastic approval of the central theme of *A Dram of Poison,* which is the damage that can be caused by amateur psychoanalysis. If as many as 1 per cent of its readers are impressed by the thesis, Charlotte Armstrong is entitled to professional gratitude. Even if none at all who could profit are impressed, the tale is a fine illustration of general preoccupation with psychodynamic concerns. It pictures a society which would have been unthinkable fifty years ago today.

The great jungle—inhabited by the id, the tyrannous super-ego, and forlorn and forgotten wanderers from the ego—still remains to be fully explored. As the horizon widens and pace of exploration increases in the other natural sciences, that of man himself proceeds painfully and slowly. But we do proceed, and we may expect to accelerate the procedure, to widen the known in the mind and to narrow the unknown, to strive in the terms set by Freud himself, to the end that where id now is ego shall be.

That the science of man's mind will keep pace with such experimental sciences as physics and chemistry seems most unlikely; that progress worthy of the discoverer will be made, one may confidently believe. But although where we are going and what we shall find there may be speculative; of the wondrous things that we have seen and that these last hundred years have seen, there is no doubt. We of our day have had the privilege, coming all too seldom down the centuries, of standing in the shadow of one of

*Armstrong, Charlotte: A Dram of Poison. Coward-McCann. New York. 1956.

the world's truly great. And for centuries to come, our explorers into the unknown may advance with the feeling that the first paths have been marked, that the worst obstacles have been cleared; for centuries it may be, they will attain with struggle and pain goals where they will recognize that Freud has been ahead of them.

For however far the road, it will be long to a land where the greatest explorer of all does not stand gigantic on the way ahead, to beckon and encourage lesser men to pass the bounds he reached long before.

BOOK REVIEWS

The Life and Work of Sigmund Freud. Volume II, 1901-1919. Years of Maturity. By ERNEST JONES, M. D. 512 pages including index. Cloth. Basic Books. New York. 1955. Price $6.75.

Volume II of Ernest Jones' definitive life of Freud covers the years of his maturity and of his greatest development. The period from 1901 to 1919 was one in which psychoanalysis grew from a small circle of practitioners in Vienna, attained a vigorous organization, saw the secessions of Adler, Stekel and Jung, and finally reached world-wide recognition. As in the first volume, Jones manages to present Freud as a human being without diminishing his stature.

Jones has divided his chronicle into a discussion of Freud's life during these critical years, his work and the development of his theories; and his character and personality. It is a method which involves some repetition and of course forecloses strict chronological order, but it permits quick consultation of concise and reliable material by way of all three frames of reference.

Complete accuracy is presumably unobtainable in a work of this sort. Jones has had access to an enormous collection of documents and records of various sorts but much evidently depends on personal recollection over a lifetime of association, and personal recollection will necessarily be faulty. It is necessarily so in this biography. Nevertheless, it is as fair, objective and factual as could very well be wished. For example, Jones chronicles the years of growing differences and the final break with Jung without bitterness and with every appearance of fairness to Jung, although he leaves no doubt as to where he himself stood.

The discussion of the development of Freud's work covers his expositions of his position, his technique, clinical contributions, case histories, the libido theory, other contributions to theory, and nonmedical applications of psychoanalysis. This is in a convenient form for consultation and could be used readily as a guide for research and as a guide to the writings by Freud himself which are pertinent to various aspects of psychoanalytic science.

Perhaps the most interesting section of this volume is that on Freud's personality. Jones pictures Freud as a fundamentally simple man who was cheerful, tolerant and yet reserved. He finds him impatient of formalities and of legal safeguards. He finds him astonishingly indiscreet in voicing personal opinions of friends and colleagues. Altogether it is a picture of a strong and fascinating, but by no means perfect, character. Yet it is one to add to the respect and admiration that one may expect any informed reader will feel for the greatest figure in the science of man in our time.

Sigmund Freud. Four Centenary Addresses. By ERNEST JONES, M. D. 150 pages. Cloth. Basic Books. New York. 1956. Price $3.75.

Sigmund Freud. His Exploration of the Mind of Man. By GREGORY ZILBOORG, M. D. 132 pages including index. Cloth. Scribner's. New York. 1951. Price $2.00.

The Legacy of Sigmund Freud. By JACOB A. ARLOW, M. D. 96 pages. Cloth. International Universities Press. New York. 1956. Price $2.00.

The centenary of Freud's birth has brought numerous appraisals and tributes from the leaders of the psychoanalytic discipline which he founded.

Four Centenary Addresses by Ernest Jones is a collection of four remarkable little essays on the nature of genius, our attitude toward greatness, psychiatry before and after Freud, and the man and his achievements. Appended is a eulogy by Jones, who is not only Freud's official biographer but was one of his earliest pupils. Of the four lectures, three were addressed particularly to professionals; the fourth was broadcast over the British radio system. Jones uses the personality of Freud to develop a theory of genius and to illustrate the curious contradiction in the characters of so many people of genius, the simplicity or credulity in ordinary affairs which so often contrasts with skepticism in scientific inquiry. The other lectures are splendid introductory material. They outline Freud's life and achievements very briefly and place him against the background of modern psychiatry.

An earlier brief work, and one of equal significance, is Gregory Zilboorg's essay on Freud's explorations into the human mind. This is a short but scholarly discussion, with a useful collection of references to the pertinent general and scientific literature. Zilboorg's writing is—to say the least—always readable, and this book is to be recommended not only for the specialist who wishes to view Freud against a general rather than a scientific background, but it is to be strongly recommended to the general reader. It is an excellent and apparently undistorted picture of a great man and his relation to his society.

Dr. Arlow's small work is a contribution to the Freud centenary from a somewhat different viewpoint. As a member of the centenary committee, he was in charge of arranging a display of Freud's work for the general public. With this as a background, he has attempted what he calls "a representative sampling," an outline organized according to Freud's different interests and correlated with his different life periods. This is also a neat introductory volume though it will convey less of Freud's theory than the Zilboorg essay. It should be of particular use to the teacher in need of an outline or in need of a general guide by which he may assign reading for students.

The Interpretation of Dreams. By SIGMUND FREUD. Translated from the German and edited by James Strachey. 692 pages including index. Cloth. Basic Books. New York. 1955. Price $7.50.

Beyond the Pleasure Principle. By SIGMUND FREUD. Translated by James Strachey. 97 pages including index. Cloth. Liveright. New York. 1950. Price $2.50.

On Aphasia. By SIGMUND FREUD. Translated by E. Stengel. 105 pages. Cloth. International Universities Press. New York. 1953. Price $3.00.

Delusion and Dream. By SIGMUND FREUD. 238 pages including index. Paper. Beacon Press. Boston. 1956. Price $1.45.

The centenary of Freud's birth sees an increasing number of fine translations of his more important works available in single publications for the practitioner and student. The specialist will presumably find the expensive acquisition of his complete writings indispensable, but the non-analyst who uses Freudian concepts, the medical student, the young physician and the nonmedical follower of Freudian psychology have found it difficult to locate suitable study and reference material.

The Interpretation of Dreams, as published by Basic Books, is the authorized translation by James Strachey of Freud's eighth and final revision of this scientific classic. It is a reprint from Volumes IV and V of the *Standard Edition,* London, 1953. Aside from that not readily available source, it has been obtainable in English only in the incomplete and unsatisfactory version translated by A. A. Brill in *The Basic Writings of Sigmund Freud* and in a London version by unspecified revisers and translators. Both of these were of the third edition (1911), whereas the eighth edition was published in 1934. Strachey's translation is presented in English that is a joy to read. It is also a translation which is perfectly suited for reference and textbook use. As is well known, this work is one in which Freud stressed the role of puns and plays on words in dreaming and related mental activities. Previous translators have substituted plays on English words for Freud's German ones, and their own anecdotes for those which Freud used, or, alternatively, they have left out the illustrations. Strachey presents the puns in German and translates. As he notes, it takes some of the fun out of it, but it lets the student know what Freud was actually talking about.

Strachey is also the translator of Freud's shorter work, *On Dreams,* brought out by Norton in 1952, a useful summary of Freud's view of the nature of dreams and of their mechanisms.

Another excellent Strachey translation is *Beyond the Pleasure Principle.* It is based on the German text of Freud's complete works and it

gives in Freud's own language his views on the existence and dynamics of the death instinct. This is a well-printed, small volume in excellent format which the student cannot afford to be without.

On Aphasia, the authorized translation by E. Stengel, is an important historic document. It is one of the few readily obtainable neurological works by Freud. It is important to the development of psychoanalysis in that Freud discussed a purely neurological subject in terms of dynamics. He leaned heavily on the work of Hughlings Jackson, which was not generally appreciated in that day (1891), and he rejected the concepts of physiological speech centers. Thus he exemplifies in neurology the viewpoint he afterward developed in psychiatry.

Delusion and Dream is Freud's first analysis of a fictional character. It is a work which his biographer, Ernest Jones, and a good many other persons consider "charming," but it has not been easily found by the English reader. In the Beacon Press paper edition it is presented with a translation of *Gradiva: A Pompeiian Fancy* by Wilhelm Jensen, the story which inspired Freud's analysis. Besides *Delusion and Dream* which pertains to *Gradiva,* the volume also includes three other related essays. The translations, all of which are excellent, are by Harry Zohn, I. F. Grant Duff, James Strachey, Douglas Bryan and Helen M. Downey.

The volumes reviewed here should, of course, be visualized with other single-book publications ranging from the recent letters to Wilhelm Fliess, issued as *The Origins of Psychoanalysis,* through *Leonardo da Vinci, Three Essays on the Theory of Sexuality* and *An Outline of Psychoanalysis* to the two series of introductory lectures—variously translated and printed. The resources thus available to the student are increasing rapidly.

Tribute to Freud. By H. D. 180 pages. Cloth. Pantheon. New York. 1956. Price $2.50.

The dust jacket of this small book reveals that H. D. is Hilda Doolittle, poet and author of prose fantasy. In it she gives impressions and feelings she had as a patient of Sigmund Freud in Vienna. The picture is an attractive one and not at all without its value as a sketch of Freud's personality and surroundings. It must be accepted chiefly, however, as an exceedingly beautiful tribute, in language which is both poetic and affectionate, to a great and much-loved healer. Included as an appendix are a small number of appreciative and characteristic letters by Freud to his former patient. Any admirer of Freud will want this volume in his library.

Magic and Schizophrenia. By GÉZA RÓHEIM. viii and 230 pages. Cloth. International Universities Press. New York. 1955. Price $4.50.

The Gates of the Dream. By GÉZA RÓHEIM. viii and 554 pages, with index. Cloth. International Universities Press. New York. 1952. Price $10.00.

Psychoanalysis and Anthropology. Culture, Personality and the Unconscious. By GÉZA RÓHEIM. XV and 496 pages, with index. Cloth. International Universities Press. New York. 1950. Price $10.00.

It seems probable to this reviewer that, as the years pass, Géza Róheim will occupy the same commanding position in the field of "psychological anthropology" that his teacher, Freud, holds in psychological medicine. With a doctorate in philosophy, Róheim, although a thoroughly trained therapist, was a medical layman, whose eminence as a scientist was primarily in a wider field. In the volumes reviewed here, he considers topics as narrow as the symptomatology of a schizophrenic patient and as wide as the spread of mankind across the length and breadth of the world.

In Part I of *Magic and Schizophrenia*, Róheim develops the thesis that magic, used alike by primitive and schizophrenic, may be the basis of realistic action in primitive culture, but is purely "imagination" magic in schizophrenia; action does not follow. He illustrates with examples, some from his own field work, from Australia, Africa, North America, Europe, Malaya, in fact from primitive and civilized cultures ranging from New Guinea to Scotland and Hungary, with illuminating notes from clinical psychoanalytic practice. In the neurotic, he finds, magic and sublimation may be identical. And he finds that mankind in general deals with the world in the main according to a *"magical principle"*—as if the outside world were "governed by our wishes or drives or emotions." He thinks we must all recognize that magic, conscious or unconscious, is "the ever-present matrix of our actions."

Part II of *Magic and Schizophrenia* gives a wealth of illustration of magical thought in a single schizophrenic patient studied intensively by Róheim at Worcester (Mass.) State Hospital when the author was doing research there. Pointing out numerous correspondences between schizophrenic and primitive magic, Róheim also cites important differences. The processes of primitive magic, he observes, are generally ego-syntonic and generally dramatized and shared by the social group; in schizophrenia, the same processes may be dramatized, but they are not ego-syntonic and are not shared by the social group. *Magic and Schizophrenia* was published posthumously from manuscripts left at Róheim's death; it has been ably and smoothly edited by Warner Muensterberger, Ph.D. and S. H. Posinsky,

Ph.D. It forms a splendid short discussion of the best psychoanalytic thought on its subject.

In *The Gates of the Dream* and *Psychoanalysis and Anthropology,* subjects closely related to the work on magic and schizophrenia are treated much more exhaustively. In the former book Róheim introduces the study of the dream by the concept that the dream is a reaction to the fact of being asleep, which, in itself, is being in the womb again. He cites the theory of Jekels and Bergler that dreaming and sleeping may be explained as the conflict of the death and life principle—although Róheim himself feels that he cannot decide on the biological validity of the death instinct. He calls on Bergler again (and on Melanie Klein) to explain phenomena related to oral aggression when he comes to discuss the subject in *Psychoanalysis and Anthropology.*

The Gates of the Dream, says the author, emphasizes the Jekels-Bergler theory of the dream as a guardian of life during sleep, and its discussion is based on his own experience, on Australian mythology and on clinical material. But it is much more than that; it is a great canvas, painted and ornamented in great sweeps and little kaleidoscopic whirls of color, depicting a universal theme in inexhaustible variation and variety—not simply from clinical notes and a single primitive mythology, but from art, literature, folklore, all over the changing face of the world. Great themes of myth and dream are depicted in rich detail: *descensus averno,* the song of the sirens and isles of the blest, the ogre, the creation, Castor and Pollux, water carriers in the moon, the Danaids—and Oedipus Rex.

In *Psychoanalysis and Anthropology,* Róheim brings his encyclopedic knowledge and vast experience down to cases—anthropological cases. The anthropologist, he notes, generally holds that interpretations of phenomena either should be within the context of their own culture—or the interpreter should explain why they are not. Limitation to one culture is not valid logically or fundamentally, says Róheim, and he proceeds to illustrate from clinical psychoanalytic practice. Such "cultural anthropology," he thinks, "tacitly negates the basic unity of mankind." And " . . . psychoanalytic interpretation is not culture bound, its methods are of universal validity. There can be many types of personality but only one Unconscious." Concerning current theory, "the anthropologists, especially those representing the personality and culture group, operate on a quasi-psychoanalytical level, they have not understood or they do not accept the existence and meaning of the unconscious."

Using his own field material as well as that of others, Róheim traces the common unconscious elements through such cultures as that of native Australia, of Normanby Island, of Alor, of the Yurok, of the Kaingang of Brazil, of the Marquesans and the Navaho—coming at length to the modern

nations of European origin. It is a detailed, comprehensive and convincing presentation. A matrilineal culture (Normanby Island) displays the Oedipus complex; certain pre-Oedipal elements such as oral aggression (Klein and Bergler) are found without regard for cultural factors; the ogre—the cannibal parent—is feared where children are very gently disciplined, as well as among the Australian tribes, some of whom eat small children when they are hungry; others, every second child.

Róheim's work in general is basic for understanding from the psychoanalytic frame of reference the workings of man and his society, savage or civilized. The three volumes discussed here should be indispensable to the serious student, whether of psychoanalysis, anthropology or sociology.

Freud on Broadway. By S. David Sievers. 479 pages including index. Cloth. Hermitage. New York. 1955. Price $5.00.

This is an amazing review of an encyclopedic volume of dramatic literature. It aims to show the influence of Freud and of other dynamic psychologists on drama as evidenced in Broadway plays of the last half century. In the process, Dr. Sievers—who has studied both drama and psychoanalysis—obtained answers to a questionnaire from 33 representative playwrights. The topics range from the supposed inheritance of mental deviation, the year around 1900, to deliberately designed Freudian theater.

The 33 playwrights who filled out the questionnaire are a small fraction of those listed in 17 pages of a name-and-title index. Consequently, much of this book can be viewed legitimately in reverse—as a Freudian interpretation of the stage rather than as the stage interpreting Freud. Whichever way it is looked at, it is an impressive and apparently reliable documentation of dynamic psychology on the modern stage. It is excellently written and is worth reading for entertainment as well as for information. It should be of reference use in either a theatrical or a psychological library.

Reading Can Be Fun. By Ellen C. Henderson. 172 pages including index. Cloth. Exposition. New York. 1956. Price $3.00.

With some deference to, or at least a bow in the direction of, modern word recognition methods, Mrs. Henderson presents here a book which a parent might use in teaching Johnny to read by a modified use of phonics. While the reviewer would make the reservation that comparatively few parents are capable of the job, he would consider this a good text for the use of those who are. It could, to his mind, have profited by some of the older spelling book exercises, but Mrs. Henderson has had long experience in teaching reading and presumably should be accepted as an authority.

The Amazing World of John Scarne. By JOHN SCARNE. 412 pages. Cloth. Crown. New York. 1956. Price $5.00.

The Amazing World of John Scarne is the autobiography of a magician who can do unbelievable things with cards. It is of considerable interest to the psychiatric and allied disciplines because Scarne devotes considerable attention to hypnotism and ESP. Scarne, acquainted with gambling and show business, is a "wise guy" in a complimentary sense—if the term can be complimentary. He knows stage hypnotists and stage mind-readers whose hypnotism and mind-reading are fakes. As his own belief, and with the added authority of Houdini, Scarne expresses the view that the doctors who practise hypnotism or write on psychic phenomena are either crooks also—or dupes. Their aim, of course, if they are crooks, is money.

Outside his own specialty, Scarne is as gullible here as the gullible people he hoodwinks by stage entertainment, or as the gullible victim of the card cheat Scarne exposes. The "wise guy" is the cynical fellow who knows a crooked policeman and a bribable office-holder and who concludes that all policemen are crooks and that all office-holders are dishonest. Scarne's gullibility, of course, is in a different field.

This magician's autobiography is an exceedingly interesting story, although awkwardly reported in spots; and it is obviously the history of an earnest and honest man whose ability with card tricks is probably unrivalled. The apprentice magician or the reader who just enjoys show business should enjoy Scarne's tale—with an appropriate warning that in regard to hypnotism and ESP his too-suspicious attitude has sold him down the river.

The Direction of Human Development. By ASHLEY MONTAGU. 404 pages including index. Cloth. Harper. New York. 1955. Price $5.00.

This is a useful survey and discussion of the trends and present directions of human society. Montagu, as is well known, has long championed the view that the role of co-operation in human evolution is of far more importance than that of competition. In the present volume his thesis is that human nature is fundamentally good, "The supreme value is love." And, "The school, like the home, must become an experience in the growth and development of one's capacities for becoming a loving human being." The author makes much of the birth trauma, concerning which he quotes Rank, Fodor and Peerbolte. He lays stress on the need of the infant and the child for love, a matter on which psychiatry is in full agreement. The result is a book capable of doing considerable good and certainly written with noble intent. Its drawback is that the author's immoderate championship of his pet theories lacks scientific objectivity if not scientific accuracy.

The Teaching of Reading and Writing. By WILLIAM S. GRAY. 281 pages including index. Cloth. Scott, Foresman. Chicago. 1956. Price $3.00.

This is a survey of methods and programs of teaching reading and writing all over the world. Published by UNESCO, there are French and Spanish editions, as well as this one in English. This work is a scientific survey, covering the roles of reading and writing in fundamental education, the influence of the teaching of language, the nature of reading in various languages, methods of teaching, findings of research, teaching adults to read, and teaching handwriting to children and adults.

There are extensive references, and there is a very evident effort at impartiality. In this respect, however, the reviewer notes the apparently complete omission of reference to Rudolph Flesch's criticism of American teaching methods. Flesch is not mentioned in the book's general index, nor, so far as the reviewer could determine, in the text or text footnotes. The question of word recognition vs. phonic teaching techniques is covered, but omission of the highly controversial Flesch dispute makes the coverage incomplete. The book, nevertheless, is valuable to any educational scientist for information and reference, and to any other scientist concerned with the present state of teaching our children to assume their roles in the modern world.

The Three R's *Plus*. ROBERT H. BECK, editor. 392 pages including index. Cloth. University of Minnesota Press. Minneapolis. 1956. Price $5.00.

This is a collection of contributions by modern educators covering modern public school education. Types of education, the much-disputed core program, English, the theater, mathematics, science and social studies, are among the topics covered, each by an informed and authoritative writer. This work could be used either for general information or for teaching. The parent who doubts that Johnny can read will not find wholehearted agreement, but he will find general concessions to the effect that word recognition is not all, and that the alphabet has its uses. For the rest, there is much material that anyone with a child in elementary or high school could profit by learning.

Marriage Happiness or Unhappiness. By TOM R. BLAINE. 197 pages Cloth. Dorrance. Philadelphia. 1955. Price $2.50.

This is a highly readable book by a trial judge who has presided in more than 10,000 divorce cases. It is free of both legal verbiage and sermonizing, and Judge Blaine writes with much sympathy and understanding of the psychological problems underlying marital discord.

The Destiny of the Mind. East & West. By WILLIAM S. HAAS. 327 pages including index. Cloth. Macmillan. New York. 1956. Price $6.50.

The mind, as reviewed in this volume by the late Professor Haas, is the ego or conscious self. He writes an essay in philosophy; one might almost say spirituality, not psychology. It is, nevertheless, as pertaining to man's conscious, intellectual and emotional component, worth psychological consideration. It is worth the particular attention of anyone who writes or plans to write on the phenomenon of mentation. Haas approaches his topic from Orient and Occident, opposite poles in thought and in the philosophy of thought. For instance, in the West, freedom means freedom to act without causation or necessity. In the East, freedom is freedom from compulsion by instinct. The West's great contribution, Haas thinks, is unity in the variety of its thought; and both East and West must contribute to the future progress of the mind. They are in contrast, he believes, as representatives and champions "of the two forms of consciousness that the human mind has thus far generated in the fulfillment of its destiny." In an appendix written particularly for this book, Dr. Haas discusses the problem of a philosophy of history. Considering the influence of Hegel, Spengler, Toynbee and other theorists of history on modern thought, this essay is something from which any reader who himself attempts to think should profit.

The Man in the Net. By PATRICK QUENTIN. 251 pages. Cloth. Simon and Schuster. New York. 1956. Price $2.75.

This competently designed and well-written mystery story is notable for a convincing picture of an alcoholic woman and for one of a group of children, which is likewise psychologically realistic. "Picture" is used advisedly. The description is of behavior, not motivation. It is, however, on a reasonably adult level, and the psychologically sophisticated will find no implausibilities. But the reader should bring his own insight.

Spooks Deluxe. By DANTON WALKER. 187 pages including index. Cloth. Franklin Watts, Inc. New York. 1956. Price $3.95.

Danton Walker is a well-known Broadway colomnist. He believes, or says he believes, in ghosts. Here he reports stories, collected from a number of friends, many of them well-known people, of their encounters with the supernatural. Anybody with a psychologist's interest in the occult should find these unusually well-presented tales well worth reading.

A Guide to a Good Marriage. By RICHARD M. STEINER. 136 pages. Cloth. Beacon. Boston. 1955. Price $2.50.

This book is written by a Unitarian minister with 20 years of experience in marriage counseling. It offers "common sense" advice which is obviously based on broad knowledge and understanding.

Jules Verne. By MARGUERITE ALLOTTE DE LA FUYE. 222 pages. Cloth. Coward-McCann. New York. 1956. Price $3.95.

Jules Verne was not only the father of modern science fiction (Edgar Allan Poe may have been the grandfather) but was a fabulously successful writer and a world figure as well. This biography, by a lady who married into Verne's family, is an account of his life and some evaluation of his writing—which appears to have been of a higher literary standard than the ordinary translations would indicate. The English of most of the latter is written in excellent French.

Verne wrote with the serious object of predicting the future or at least of indicating what the future might be. The personality organization which must have impelled him to do so is a mystery, and remains a mystery despite this new biography. When a man spends his life and an apparently considerable literary talent in the chronicling of imaginary explorations, there must be powerful motivation. Verne was a tremendous exhibitionist but otherwise a conventional and conforming person. His sudden permanent retirement to his Amiens home after suffering a foot injury in his late 50's is the one real abnormality Madame Allotte de la Fuye chronicles. She sets down a great deal about which the student of psychology may speculate, but either does not find or does not disclose any definitive material in the psychological field.

The Fourth World. By DAPHNE ATHAS. 318 pages. Cloth. Putnam. New York. 1956. Price $3.75.

This novel describes the overthrowing of a director of an institute for blind children who adheres to half-authoritarian principles in dealing with the blind. Whether there really exist disciplinarians who believe that the blind should never marry, is unknown to this reviewer, just as he believes that a not-blind person has nearly insuperable difficulties in the way of empathy with the blind. Hence, many of the incidents cannot be psychologically checked.

Dynamics of Psychotherapy. By P. M. SYMONDS. 200 pages. Cloth. Grune & Stratton. New York. 1956. Price $5.50.

One of those rather typical "on-the-one-hand, but on-the-other-hand" eclectic books on psychotherapy is written by a professor of education at Teachers College, Columbia University. Some uncontested facts are reported, mingled with a lack of synthesis of current findings. Sometimes, only the oldest theories are included; sometimes, misunderstandings are rampant. The worst parts are about the super-ego, pre-Oedipality and the newer theories on the structure of the neurotic symptom. It is probable that the uninitiated reader will get from this book a very unprecise picture of what is really going on in the science of psychotherapy.

Progress in Psychotherapy. FRIEDA FROMM-REICHMANN, M. D. and J. L. MORENO, M. D., editors. 352 pages. Cloth. Grune & Stratton. New York. 1956. Price $8.50.

This remarkable book offers very comprehensive studies of psychotherapeutic efforts and their underlying psychologies and/or philosophies of the last decade. A short survey of the history of psychotherapy by Frieda Fromm-Reichmann precedes the presentation of *Progress in Psychotherapy.*

The principles of psychotherapy and their theoretical orientation comprise Parts II and III of the volume. Part IV introduces the readers to psychotherapeutic efforts abroad, as they are taught and practised in Austria, Great Britain, France, Germany, South America, Spain and Switzerland.

The dynamic summary (Part IV) enlivens the book and opens therapeutic potentialities of the future.

The book is an outgrowth of the aims of the section of psychotherapy of the American Psychiatric Association. Forty psychotherapists have contributed to *Progress in Psychotherapy;* and, as stated in the summary, 142 techniques are mentioned.

References to literature, author index and a subject index enhance the value of the book. The challenge and the spirit of the book are indicated to a certain extent in Dr. Moreno's final sentence of his summary: "In the spirit of our time, the old adage, 'Physician, heal thyself,' would become, 'Community, heal thyself.' "

Progress in Psychotherapy has to be read to be appreciated.

Murderer's Moon. By CONRAD PHILLIPS. 238 pages. Cloth. Associated Booksellers. Westport, Conn. 1956. Price $3.50.

Conrad Phillips is an English journalist who has set down here reminiscences, or sketches of four British murderers. They are the sadistic killer, Heath; the mass-murderers, Haigh and Christie, and Donald Chesney, who killed his wife and mother-in-law and escaped trial by way of suicide. The first three stories have been told better elsewhere and Phillips' attempt to assess them psychologically is pathetic. He says of Heath: ". . . one who reasons, no matter how badly or how immaturely, is not insane." He considers Christie a "disgusting monster who, it is difficult to believe, had human birth. But he magnanimously pronounces Christie's parents innocent and quotes C. G. Jung to support his point. The psychology is as amateurish in the story of Chesney but this case is worth anybody's reading, for, as it did not come to trial, it is not commonly reported. Even here, however, the reader will have to supply his own emotional framework.

International Record of Medicine. Volume 169, No. 11, November 1956. MD Publications. New York. 1956.

The November 1956 issue of the *International Record of Medicine* is devoted, with the exception of a single article, to a symposium on medicine and writing. A review, therefore, seems well indicated, and the reviewer is glad to recommend it as a worthwhile contribution to the growing number of publications on medical writing.

This is the second recent symposium on the subject to be brought out by MD Publications. *Medical Writing*, the first, should also have cordial recommendation. Felix Martí-Ibañez, M. D., is editor of the first symposium and also of the second, by virtue of being editor of the *International Record*. The present contribution contains, as did the previous one, an article by him; the present one is "Minerva and Aesculapius: The Physician as Writer." Morris Fishbein, M. D., contributes a short and pithy paper on "Plain Talk and Clear Writing."

John F. Fulton, M. D., is the contributor of an exceedingly useful article: "The Principles of Bibliographic Citation." Many an otherwise good medical writer appears to be bewildered by the process of compiling, arranging and verifying bibliographies and references. Any medical editor can testify to the prevalence of carelessness or incompetence in this regard. For this paper alone, the reading of this compilation is strongly recommended.

Jean Cocteau. By MARGARET CROSLAND. 238 pages Cloth. Knopf. New York. 1956. Price $5.00.

From all published—and unpublished—accounts, as well as from the actual writings, of Jean Cocteau, one would expect that he would yield a varied and richly fascinating biography. Yet, it is difficult to find the man in this one. Instead, the reader is treated to a dry sequence of dates, to an itemized chronology of new Cocteau productions, and collaborations, and faintly convincing antedoctes. A brief forward notes that Cocteau encouraged the author in her work. But it is hardly conceivable that he would have encouraged its grossly pedestrian and at times actually annoying style. It is all the more a disappointing piece of work because its subject promises so much.

The Professor and the Fossil. By MAURICE SAMUEL. 268 pages. Cloth. Knopf. New York. 1956. Price $4.00.

This bitter, sarcastic, in parts brilliant, refutation of Toynbee's *A Study of History*, centers exclusively on Toynbee's views of the Jew. As is well known, Toynbee described Jews as "fossilized relics of societies now extinct." The author takes issue with the historian's inconsistencies, biased contradictions, and half-anti-Semitic utterances.

Heredity in Health and Mental Disorder. By FRANZ JOSEF KALLMANN, M. D. 315 pages. Cloth. Norton. New York. 1953. Price $6.00.

In a footnote to this small book, Nolan D. C. Lewis, M. D., notes that "an almost overwhelming amount of factual evidence must be presented in order to establish a genetic theory of schizophrenia or any other so-called 'functional' mental disorder." Kallmann does not attempt here to present such overwhelming evidence. Rather he presents a greatly compressed report of the status of scientific investigation into the heredity of mental disorder, as given in a series of Salmon Memorial Lectures. Kallmann is one of the best-known workers in the field of psychiatric genetics. As representative of his position, he declares: ". . . a true schizophrenic psychosis of any variety may be expected to be developed only by a homozygous carrier of a specific gene producing a specific type of vulnerability through a metabolic disturbance in the enzymatic range." Kallmann states that point of view, apparently conservatively, and without fanaticism.

Persons desiring a research report or a reference book will have to go elsewhere, but the present volume is a useful résumé of a highly important scientific point of view. Kallmann ends with the pertinent reflection that to make genetics significant in public health now and in the future the work of very many groups of qualified and unselfish men will be needed. He mentions the social worker, the psychologist, the statistician, the medical specialist, and the family physician. Whatever one's views of the present status of the genetics of mental disorder, this is a standpoint on which all informed persons should agree heartily.

The Side of the Angels. By JEAN-LOUIS CURTIS. 416 pages. Cloth. Putnam. New York. 1956. Price 4.50.

A young French writer attempts to recapture the spirit of a group of Parisians immediately after the liberation, at the end of World War II. After an interesting start, the author hides behind unlimited verbosity a more than limited intuitive understanding. His initial intention to explain the psychology of collaborationists and of members of the *Maquis* is not worked out psychologically; both are described as nondescript neurotics. Peculiarly enough, one gets the impression that the author's sympathies are with Petain.

Your Child and Mine. By JOHN DALLAVAUX. 59 pages. Vantage. New York. 1956. Price $2.00.

Common-sense advice to parents stresses three errors: doing too much for the child, giving the child too much in order to win his love, backing him in every situation, whether he is right or wrong. Since the booklet totally neglects unconscious factors, it is at least outdated.

Der Kainskomplex. By Dr. Jean Felber. 70 pages. Paper. Urban & Schwarzenberg. Wein-Innsbuck. 1956. Price: Schilling 36. Deutsche Mark 6.

The general definition in Jung's analytic psychology of the Cain complex as jealousy of the older brother toward the younger, for fear of loss of parental affection, does not suffice for Felber. He feels it considers only one aspect of the problem, and that analyses of the collective psyche and of the familiar unconscious have enlarged and changed the concept.

To analyze the Cain psyche, Felber applies three psychological methods: The first deals with Cain, the archetype, based on the description in Genesis; the second leans on Szondi's work; the third is practical analysis.

Using Szondi's instinct pattern, Felber places Cain in Class P which contains the disposition to paroxysm; and he deduces the methods of therapy from further considerations. He recognizes a relationship between the factor "e" and homosexuality on the one hand and paranoid schizophrenia on the other. The killer, the suicide, the epileptic, the homosexual and the schizophrenic, according to Felber, all suffer from the Cain complex.

The psychopathological phenomena which can be derived from the destructiveness of the Cain instinct include, besides paranoid schizophrenia, homosexuality, hallucination, fear and the phobia, hysterical conversion, organ neurosis, and psychosomatic ailments. Felber deals with these phenomena in detail.

As to therapy, Felber maintains that by means of analytical therapy and with the help of Szondi's examinations it is frequently possible to lead the patient onto a road where the materialization of the instinct may be reconciled with society and self-criticism. The book concludes with case histories from Felber's practice. The whole, of course, is based on C. G. Jung's theories, which are not too familiar to American practitioners.

Dreams and Nightmares. By J. A. Hadfield. 244 pages. including index. Paper. Penguin Books. Baltimore. 1954. Price 65 cents.

Dr. Hadfield is a psychiatrist and neurologist who was one of the founders of the famous Tavistock Clinic and its first director of studies for training doctors. His work on dreams is an exposition and a short text. His point of view is dynamic but not strictly Freudian, and some of the criticisms he makes of Freudian theory seem possibly due to semantic difficulties if not to outright misunderstanding. He does not take into account some of Freud's own later views as well as the newer studies by others in the psychoanalytic field. Nevertheless, this is an interesting, well-written and useful book, worth the attention of both the psychotherapist and the student of dynamic psychology.

Being and Nothingness. By JEAN-PAUL SARTRE. Translated by Hazel E. Barnes. 638 pages including index. Cloth. Philosophical Library. New York. 1956. Price $10.00.

This heavy tome is, its translator notes, a translation of all of Jean-Paul Sartre's *L'Être et le Néant*. It includes all the selections published three years ago under the title of *Existential Psychoanalysis*. In a 44-page introduction, Miss Barnes attempts to condense and outline the ideas developed in Sartre's earlier work and presented in this book. She remarks that he is one of the few philosophers of our century to develop a "total system." It is impossible, of course, to indicate what that system is in a review. Sartre appears to hold that there is no ego consciousness but only consciousness of the ego. Consciousness, he thinks, infinitely overflows the "I." Sartre believes that man is the being by whom nothingness comes into the world. He thinks existence is absurd, holds that man is animated by an irrational desire which leads to a non-existent ideal which is basically self-contradictory. The existentialist ideal of living appears to be passionate commitment.

If this does not seem to make sense, blame Sartre and his translator. More than 600 pages in this book are devoted to outlining and supporting his position. There is a 6½-page "Guide to Special Terminology" as a certainly necessary aid to readers.

Sartre's "psychoanalysis" is also nothing to be comprehended in 10 easy lessons. He notes that "the *principle* of this psychoanalysis is that man is a totality and not a collection." The goal of this psychoanalysis, he says, is to decipher man's empirical behavior patterns. The Freudian will hardly quarrel with these statements but will be bewildered by the reasoning and technique. Sartre does not believe in the unconscious, and it is questionable whether his "psychoanalysis" is advanced seriously as a therapy. It seems rather an attempt at philosophical explanation. Sartre is worth the attention of psychiatry because his philosophy appears to have a growing following and because it or its abuse comes within the scope of dynamic psychology. His own work, as here presented, is as authoritative an exposition and reference as one can find on the subject.

The Psychoanalytic Study of the Child. Vol. VIII. R. Eissler, A. Freud, H. Hartman and E. Kris, editors. 412 pages. Cloth. International Universities Press. New York. 1953. Price $7.50.

The 1953 issue of this worthwhile publication is not up to its own standards. Many of the papers are either simplifications, unproductive speculation, or rehash of the already known. A single oasis in this desert is Géza Róheim's posthumously published study, "Fairy Tale and Dream."

Der Wartegg-Zeichentest in Dienste der Erziehungsberatung. (The Wartegg Drawing Test in its application for Educational Counseling). By MARIA RENNER. Evaluation by Vetter. With a foreword by Prof. Dr. August Vetter. 60 pages, including bibliography and a set of 23 photographic samples. Ernst Reinhardt Verlag. Munchen-Basel. 1953. Price, Paper, Fr. 7.80; Cloth, Fr. 9.50.

The Wartegg Drawing Test, known and applied in Europe for a number of years, receives, in this little publication, a very able new evaluation which widens its applicability considerably. While Wartegg originally evaluated his test statistically and typologically, Maria Renner experimented successfully with it and found that it can be of considerable worth as a projective technic. Its place in the battery of commonly given tests would be possibly between the HTP (house-tree-person) and the Bender Gestalt. It contains considerable potentialities; and very extensive studies and experimentation will be required to acquire full command over its meaning. However, the experienced clinical psychologist will soon find principles for interpretation and evaluation. It is to be hoped that an English edition of the material may soon be obtainable, for the details must be studied in the original.

Poet and Psychiatrist. A Critical Portrait of Merrill Moore, M.D. By HENRY W. WELLS. 325 pages. Cloth. Twayne. New York. 1955. Price $5.00.

Henry W. Wells' critical portrait is a study of literary expression, subject and style. Wells is a frank admirer of the prodigious Merrill Moore who is either a psychoanalyst and poet or a poet and psychoanalyst. Dr. Moore has written some very splendid verse and some which many critics find indifferent. His work naturally reflects his life, his education in the South and his psychoanalytic practice in Boston. Moore's poetry embraces everything from Nora, the cook's, "dowdy, dirty, ugly" hat to Gallileo. It has been extensively reviewed and most psychiatrists may be assumed to be acquainted with it and to appreciate it.

Besides covering Moore's verse, Wells' book includes a bibliography of 143 scientific articles, with a reprint of one of the more general psychoanalytic efforts, a note on conchology which originally appeared in *Imago* in 1942. The whole picture, however, is that of a man's works rather than of a man's personality. One learns little from it of Moore's personal life, of his family, avocations, interests and so on, other than those in verse and psychoanalysis. The volume should be welcome, however, to anybody who has an interest in the literary possibilities of psychoanalytic science.

The Annual Survey of Psychoanalysis. Volume III. JOHN FROSCH, M.D.; NATHANIEL ROSS, M.D.; SIDNEY TARACHOW, M.D. and JACOB A. ARLOW, M.D., editors. 682 pages. Cloth. International Universities Press. New York. 1956. Price $10.00.

This third effort to review current psychoanalytic literature covers 263 articles and nine of the 30 or more books listed in its bibliography. There is a two-year gap between the publication of Volume III and Volume II, and Volume III covers the literature four years previous to its publication. The editors note that they are concerned by this delay but feel that they are publishing a book which should be a future source of reference and that detail, accuracy and reliability are more important than meeting a publication deadline. Volume III is, like the two preceding volumes, divided into nine sections, ranging from critique and methodology to applied psychoanalysis. Eighteen publications have been covered. They comprise the American and British literature, the *Revista de Psicoanalisis* and the *Revue Française de Psychoanalyse*. The index covers 28 pages.

It is the reviewer's impression that Volume III is a material improvement in coverage and presentation over the first two volumes and that the editors' aim to create a useful reference work is somewhat nearer accomplishment.

A Dictionary of Pastoral Psychology. By VERGILIUS FERM. 336 pages. Cloth. Philosophical Library. New York. 1955. Price $6.00.

There is definitely a need for a sort of dictionary to define for the minister the various terms used by the psychologist, the psychiatrist, and the psychoanalyst. In his own style, the pastor is now using psychotherapy based upon psychiatric and psychological research.

In his preface the author states: "This volume makes no pretense of exhausting a complicated subject. It is one author's attempt to select from the general field of psychology those terms of interest which have some relevance to the minister's own use of psychological material—to direct his thinking in the accepted channels of the psychological field. . ."

Many psychiatrists and psychoanalysts may not fully agree with the definitions given in this book, but they are simply expressed and are correct in substance. In addition to the definitions, the book contains a great deal of information relative to pastoral psychology which will broaden the viewpoint of the psychiatrist himself.

Growth and Structure of Motives. By JAMES OLDS. 264 pages. Cloth. Free Press. Glencoe, Ill. 1956. Price $5.00.

This book of "psychological studies in the theory of action" (subtitle) attempts the explanation of motivations—with the exclusion of the unconscious. That this should be possible in 1956, is amazing.

Listening With the Third Ear. By THEODOR REIK. 514 pages. Paper. Grove Press. New York. 1956. Price $1.95.

More and more of the classics, or the standard works, of psychiatry and psychoanalysis are being made available in a format and at a price within reach of the student. *Listening With the Third Ear,* originally published at $6.00, is presented in paper covers by Grove Press at a little less than a third of that price.

The content of this important book is well known in psychiatric circles. It is a collection of essays, observations and notes on technique from the many years of psychoanalytic practice of one of Freud's most brilliant pupils. It is a technical volume, one not intended for general reading, perhaps not even for the general reading of the uninitiated physician, but it is written in a vivid style; it is a piece of literature as well as a work of instruction, and it can be read for pure pleasure. The present edition will be most useful in the hands of the young psychiatrist and psychologist. Reik's notes on the mechanisms of psychoanalytic practice and the pitfalls confronting the analyst—or other interpreter of psychic phenomena should be invaluable.

Living Magic. By RONALD ROSE. 240 pages. Cloth. Rand McNally. New York. 1956. Price $3.75.

This book is an inquiry by an Australian psychologist and his wife into the extent to which extrasensory phenomena are involved in primitive Australian "magic" practices. The Roses approached the natives with a frank statement that they wanted to learn about magic practices that white men couldn't perform. They collected material, partly by the questionnaire method and partly by the encouraging of reminiscences; and they would be the first to agree that they have not gone into the dynamics of the phenomena they investigate.

Their interest was rather in the fact of ESP than in its explanation. The author concludes that, mixed with magicians' tricks and hypnotism, there is a large body of extrasensory material. He finds that telepathy is rare, as with white people, but also thinks that the aboriginal "clever man" appears able to exercise ESP at a conscious level. He thinks suggestion is at the core of all of the aboriginal doctors' cures and that it is the key to magical killings, which he accepts as actually occurring.

The Powder Keg. By FRANCES MARION. 303 pages. Cloth. Little, Brown. Boston. 1954. Price $3.50.

This book is a sensational and undocumented novel about women's prisons, in which the emphasis is on the horrible.

A New Approach to Schizophrenia. By JULIUS I. STEINFELD, M. D. 195 pages. Cloth. Merlin Press. New York. 1956. Price $4.95.

Dr. Steinfeld died unexpectedly in June 1956 before he could witness the publication of his new and remarkable book. He was medical director of the Forest Sanitarium, Des Plaines, Illinois.

In *A New Approach to Schizophrenia* he presents his research, his clinical studies, his conclusions, his therapies based on very early physio-neurological and psychological developmental data, throwing a new light on the hypothetical etiology (or etiologies) of schizophrenia and allied mental aberrations. He stresses a psychosomatic and/or physio-neurological approach, and also takes genetic facets into consideration. He illustrates his hypothesis by 40 case histories and demonstrates the existence of a traumatic situation on the vegetative stage of development in practically all of his schizophrenic patients. He calls this hazardous situation in the infant (especially the neonate) the "hunger trauma," and he points out and illustrates the oral syndrome in schizophrenia.

The author's therapeutic procedures endeavor to reach the "core" of the psychosis through stimulation of the "vegetative" brain via ECT before intensive psychotherapy can be successful. With this type of treatment, he accomplished excellent remissions in a comparatively short time. He realized also that periodic supplementary treatment periods of short duration are needed as well as what he calls "symbiotic" relations, in order to maintain a comfortable remission level.

There is a challenge for prophylaxis inherent in this hypothetical "hunger trauma," especially regarding routines in feeding the neonate.

This book is of interest to all those with an open mind, who are dealing with problems of mental hygiene and mental illness. It is constructive and has to be read to be appreciated. An enlightening bibliography and a comprehensive glossary enhance its value.

Intelligent Layman's Medical Dictionary. By HARRY SWARTZ, M. D. 306 pages. Cloth. Ungar. New York. 1955. Price $4.75.

It may very often be advantageous if the patient does not understand the doctor's "big" words, but the public is being informed more and more as to the causation, treatment, etc. of disease. For this reason, a dictionary explaining terms in simple language is definitely needed.

Two hundred and seventy-three pages of this book are devoted to the definitions of not only common medical terms but of many little-used terms and colloquial expressions. Following these, are tables of the sources and uses of vitamins and of hormones, weight tables, an obstetric table, the Hippocratic Oath, plates of many sections of the human body and, finally, a marvelous index and cross-reference guide.

Dictionary of Anthropology. By CHARLES WINICK. 579 pages. Cloth. Philosophical Library. New York. 1956. Price $10.00.

This volume is described on the dust jacket as "the only collection in any language of the specialized vocabularies of all the fields of anthropology."

The compilation of such a book is an important and useful endeavor. Winick's work, however, has the drawbacks to be expected in a new dictionary covering a new field. There are some strange omissions and some even stranger inclusions. For example, "Mixtec" is defined but not "Toltec." "Aztec" is defined as a language only, not as a people or a culture complex. For some reason the editor has included authorities in the field only through the period ending in 1900 and there are omissions here—Darwin, for instance. The intentional time limitation means that the book cannot be used to look up the dates of such important people (or their general fields) as Géza Róheim, Bronislaw Malinowski, or Margaret Mead. Examples of peculiar inclusions are China clay, beer, *bêche-de-mer,* broad bean, underworld and mythical island. It seems to this reviewer that these are self-evident, or, in the case of *bêche-de-mer,* not anthropological.

A definition which certainly needs editorial attention is that of "Meroitics." The definition is "A group of exquisite Egyptian funeral vases, dating from the Twenty-Sixth Dynasty. They were painted with a simple well-executed design." The reviewer is not a specialist and does not want to assert flatly that there are no Twenty-Sixth Dynasty vases of this description propperly known as Meroitics. But "Meroitic" is a geographic adjective generally referring to a specific area of ancient Ethiopia. It is not so defined in this dictionary, which is a regrettable omission. If, in the plural it can also be applied to any form of Twenty-Sixth Dynasty vases, there should be an explanation. The best known Twenty-Sixth Dynasty vases would be commonly supposed by non-specialists to be Saite, which is something very different from Meroitic.

This may seem to be a lot of cavilling; and it is not meant to demonstrate that this is not a useful volume. It is intended to point out that when a revision is issued there are many points of which more account should be taken.

The Marble Orchard. By MARGARET BOYLEN. 237 pages. Cloth. Random House. New York. 1956. Price $3.50.

A pompous and pretentious novel hides both attitudes behind scurrile irony about a girl in Iowa who is blinded by an accident, regains her sight, and makes a secret of it. The reason is: Blindness "robbed me of my natural enemies." Why publish such stuff? Some editor must have mistaken the emptiness of this book for "beautiful style."

From Medicine Man to Freud. JAN EHRENWALD, M. D., editor. 416 pages including index. Paper. Dell. New York. 1956. Price 50 cents.

If there has ever been a completely satisfactory anthology of anything, this reviewer has never encountered it, but Ehrenwald in *From Medicine Man to Freud* has done a better job of selecting, editing and commenting than any reader has a right to expect. He traces the background and history of psychotherapy and dynamic psychology from the ancient clay tablets of Assyria and the celebrated Ebers papyrus of Egypt to modern psychoanalysis. There are excellent readings from Plato and Aristotle, and Hippocrates' famous essay "On the Sacred Disease" is included. Dr. Ehrenwald has given eminently fair discussions of witchcraft, of modern religious miracles, and of Christian Science. In the narrower field of medicine proper, the excerpts from Paracelsus to our time come close to giving a short history of modern psychiatry.

This book is paper-bound; it costs 50 cents; and no student of psychiatry, psychology or any related discipline of social science should be without it. Teachers should find it valuable for assigning reading.

The Ancient Maya. Third edition. By SYLVANUS G. MORLEY. Revised by George W. Brainerd. 494 pages including index. Cloth. Stanford University Press. Calif. 1956. Price $10.00.

This is a third edition, bringing completely up to date Sylvanus G. Morley's magnificent archeological survey, *The Ancient Maya.* The Maya were a people sometimes described as having left an art and architecture which is thoroughly schizophrenic. Whether this is so, is as it may be (this reviewer doubts it); but the Maya way of looking at life is so very different from ours that no student of modern society or of modern personality can fail to find it illuminating and instructive.

Morley's survey, originally published in 1946, should be comprehensible by the educated general reader but it is also an outline, with an excellent bibliography, for the serious student. Dr. Brainerd, who revised the late Dr. Morley's work, himself died before the revision was completed. It was finished very competently by Mrs. Betty Bell. This new edition contains a good deal of material which was not available at all a decade ago and which illuminates considerably, although it does not cast an entirely new light on, the whole subject of early middle-American civilization.

The Monogamist. By THOMAS GALLAGHER. 248 pages. Cloth. Random House. New York. 1955. Price $3.50.

A mild case of middle-age revolt is described with a maximum of naïveté and a maximum of psychological lack of understanding.

Learning: Reinforcement Theory. By FRED S. KELLER. 37 pages. Paper. Doubleday. New York. 1954. Price 85 cents.

Perhaps the most outspoken, if doctrinaire, learning theorists today are those who follow the path of Skinner's descriptive behaviorism as succintly illustrated in this brief volume. Discarding the array of inferred, hypothetical construct—i.e., drive, habit, etc. that other learning theorists (and most psychologists) evoke to indicate what goes on within the organism —the Skinner followers stubbornly refuse to step beyond the line of empirical data. All else, they hold, is fancy and nonsense. If we cannot directly observe drive or habit and the like, we have no business talking as though they exist. At the most, we may properly speak of the relationships between responses or patterns of responses and certain specified antecedent stimulus operations. It is the network of empirical laws describing such relationships that provides the most reliable and productive basis for a general theory of behavior. Such is the view advocated by Dr. Keller.

He convincingly demonstrates that this approach produces a rich reward of empirical information as to how learning occurs. Such topics as the distinction between operant and respondant behavior, positive and negative reinforcing stimuli, extinction, and primary and secondary reinforcing stimuli, are lucidly discussed and illustrated. The roles of generalization, discrimination, and chaining are concisely formulated and clarified by relevant experimental evidence. In all, the author has contributed a stimulating and highly intelligible summary of one important theory of learning.

How to Get Along With Children. By FRANK HOWARD RICHARDSON, M. D. xii and 172 pages. Cloth. Tupper and Love. Atlanta, Ga. 1954. Price $2.95.

Dr. Frank Howard Richardson, author of *How To Get Along With Children,* is too dogmatic and self-assured in his book and seems to imply that he has all the answers—pediatric, psychological, medical, psychiatric —about children's tantrums, sleeping problems, eating, stuttering, playmates, bad language, discipline, nagging, sex matters, and all of their feelings and emotions and actions. He suggests formulas in his answers; and functional experience suggests some better ways than the good pediatrician's dictates. Dr. Richardson obviously knows children, and feels they are the product of love. But this is a realistic world; and the author sermonizes unrealistically at times and over-idealistically. Dr. Richardson also tries so hard to encompass so much in less than 200 pages that he fails to deal adequately enough with such factors as learning, development, or maturation.

Psychosomatic Aspects of Surgery. ALFRED J. CANTOR, M. D., and ARTHUR N. FOXE, M. D., editors. xii and 220 pages. Cloth. Grune & Stratton. New York. 1956. Price $6.50.

These papers constitute the proceedings of the first annual meeting of the Academy of Psychosomatic Medicine held in New York City, October 1954. The emphasis is on the importance of the concept that "psychosomatic medicine is medicine," and the papers reach toward the unattainable ideal of a surgery that avoids emotional trauma to the patient. The purpose of surgery, and the purpose of medicine in general, is to make the patient well.

The surgical "success" who is so crippled emotionally that he ceases to function at a normal level must be considered a failure—and whether the failure is considered to be surgical, medical, or psychiatric is merely a play with words. In the present volume, two or more authorities discuss aspects of care in each different type of surgery, and the reader thereby gains increased understanding of the problems involved.

Everyone gives lip service to the idea that medicine is not, and cannot be, an assembly-line type of procedure. This book, and books like this, will help to equate this theme with actual practice.

A Pictorial History of the American Indian. By OLIVER LA FARGE. 272 pages including index. 350 illustrations, many in full color. Cloth. Crown. New York. 1956. Price $7.50.

Oliver La Farge is an anthropologist, a highly successful novelist and an authority on the American Indian. The present volume is not anthropology but is made up of the stuff on which anthropology is based. It is an exceedingly broad and brief review of the pre-history, history and present situation of the Indian from the east coast to the west. The reader who is interested in anthropology will find this volume useful in relating his particular area to the whole—placing the Navaho, the Cherokee or the Yurok, for instance, in the broad framework of Indian culture. The book, of course, is reliable, is well written and is altogether the sort of thing which might be valued in either a general or a scientific library.

A Man's Estate. By EMYR HUMPHREYS. 279 pages. Cloth. McGraw-Hill. New York. 1955. Price $3.75.

An interesting book of a Welsh writer in an unfamiliar setting: a Welsh family. Although the author constantly stresses the hatred in that family, his description of some of its members shows that he intuitively understands the psychological substructure. For example, one of the characters proclaims: "The world is full of rogues and bitches and sluts," only to proceed to perform a typical masochistic-provocative action.

Land of the Moon-Children. By CLYDE E. KEELER. 207 pages. Cloth. University of Georgia Press. Athens. 1956. Price $4.50.

Dr. Keeler is a biologist and a medical geneticist. He spent five summers studying the San Blas Indians and their "moon-children," and this book is one of the results. It is not a scientific book although he does give a most sketchy report of his scientific conclusions. These are that the albino moon-children are genuine mutants with a long ancestry of the mutation and that there is a second light-skinned strain among the Cuna Indians which may be related to white ancestry. Presumably there will be another, and scientific, report on Cuna genetics.

The major part of the book, however, is taken up with a description of the little-known Cunas, the circumstances of their life, their customs and some of their folk beliefs. All this, however, is fearfully disorganized. The anthropologist will find in it raw material only—and this interpreted all too often from the frame of reference of fundamentalist Protestantism. Dr. Keller is frankly and understandably pleased with the progress of the Baptist missionaries on the San Blas coast. But this bias distorts and confuses what might have been a valuable scientific discussion of an unusual and fascinating people.

Picasso and the Bull. By VINCENTE MARRERO. 132 pages. Cloth. Regnery. Chicago. 1956. Price $3.00.

Picasso's art is a reflection of symbolism which might be too much debated. It can be schizophrenic or a controlled, conscious endeavor to depict the irrationalities and cruelties of man as they may be supposed to exist in the unconscious. Marrero takes up a single but important theme, Picasso's preoccupation with the bull. He traces the bull in ancient myth, notes the evidence of a pre-historic bull cult in Spain, and expresses the belief that the modern bullfight is the survival of unthinkably ancient ritual. To Picasso, he says, the bull is the symbol of brute force and ugliness. He illustrates with reproductions of Picasso works from "Guernica" to "The Wounded Horse."

This is a neat and provocative essay. It is a convincing discussion of Picasso's preoccupation with the predominance of evil and of Picasso's own masochism. Marrero now and then seems on the verge of a more penetrating interpretation. He pictures Picasso as enclosing life in two halves of an "oviform," one half light for good, the other dark for evil. "But in the end the duality is completely resolved, and the circle is broken: the bull will dominate . . ." Yet the author nowhere specifies the phallic nature of this destroying Moloch. Nevertheless, the elements are there and both the student of comparative religion and of dynamic psychology should enjoy this short and intelligent study.

Encyclopedia of Morals. VERGILIUS FERM, editor. 682 pages including index. Cloth. Philosophical Library. New York. 1956. Price $10.00.

It is much easier, as everybody knows, to point out what is wrong with such an encyclopedia as this one, than it is to assess its scholarship and estimate its usefulness properly. For instance, the only text entry under "homosexuality" (which is commonly considered, among other things, a matter of morals) reads: "*see* Soviet Morality, current"—this, in spite of the fact that moral writings of Plato, Aristotle and others are included, philosophers whose own psychosexual organizations must find some reflection in their teaching. After entering this complaint, it is a pleasure, however, to say that this is a scholarly volume of considerable scope which should be of considerable reference use and of real value to students. The text entries range from "abnegation" (see Schopenhauer) to "Zweig, Stefan" (see Freud).

Despite its label, this compilation is necessarily selective rather than encyclopedic. Such a subject as quarreling, for instance, may be indexed as a cross reference to an article on a single primitive tribe. The contributions are rather generally from philosophers and theologians rather than social or psychological scientists. However, Walter Kaufman, of the Princeton University philosophy faculty, contributes an excellent short article on Freud. A well-done review of existentialism is presented by another philosophical writer. The book has a large name index and the text is a rather good topic index in itself, with the reader referred from the alphabetical listings to the principal articles concerning his subjects. On the whole, this should be a worthwhile book in any general reference library.

Progress in Neurology and Psychiatry. An Annual Review. Volume IX. E. A. SPIEGEL, M. D., editor. 620 pages. Cloth. Grune & Stratton. New York. 1954. Price $10.00.

The reference material in this thick book is tremendous. The contributors compiling it have selected and condensed over 3,700 papers.

It is impossible to list the subjects in detail. Part I covers the basic scientific subject matter relative to neurophysiology. Part II reviews all aspects of neurology, and Part III lists material pertaining to all branches of psychiatry.

The volume is not the type that one picks up for an evening's reading. It is definitely a reference book with only a smattering of information about the articles reviewed. It is a "source-material" book.

Handbook of Social Psychology. GARDNER LINDZEY, editor. Two volumes, 1226 pages. Cloth. Addison Wesley. Cambridge, Mass. 1954. Price one vol., $8.50; set, $15.00.

The appearance of these two excellent volumes is an awaited and welcomed event, for they represent the slow and arduous assembly of a scientific discipline of social psychology. One of the more important indices of a developing science is the increasing integration of its disparate and scattered components. In general, the behavioral sciences have hardly stepped above the level of observation and correlation of empirical events. Thus, the present work is received happily.

It does not present a theory of social psychology; but provides, in 30 papers, a constructive survey of the basic theoretical building-stones, analytical methods, and research applications, from which such a theory will probably evolve.

The first volume is devoted to theory and research methods. Written by acknowledged authorities, it contains lucid and comprehensive statements of the major building-stones: learning theory—the contiguity, reinforcement, and cognitive formulations; psychoanalytic and field theory contributions and applications to social psychology, and the development of role theory. Of particular interest to many will be the concise exposition of new advances in quantitative analysis, in statistical and observational techniques, and in attitude and sociometric measurement.

The second volume is devoted to "special fields and applications" and deals in general with "the individual in a social context, group psychology and phenomena of interaction, and applied social psychology." Among the more important and interesting papers in this volume are those on social motivation; perception of others (incorporating the "New Look" orientation); the nature and effects of communication; and the psychological aspects of social structure.

In brief, the *Handbook* is a scholarly, conscientious and representive work and is, perhaps, the first major publication of its kind in the area of social psychology.

Beyond Doubt. By MARY LE BEAU. 179 Pages. Cloth. Harper. New York. 1956. Price $3.00.

Mary Le Beau's "record of psychical experience" is a patently honest account of what the author believes to be communication with the spirit world. Some of the material reported should be of considerable interest to students of dynamic psychology. The book is, however, more of a religious than a scientific work and does not cast much light on the scientific problem of ESP.

CONTRIBUTORS TO THIS ISSUE

FRANCIS J. BRACELAND, M. D., Sc. D. Dr. Braceland is president of the American Psychiatric Association, in which capacity he was invited by this QUARTERLY to introduce this centenary memorial issue in honor of Sigmund Freud. He is psychiatrist-in-chief of the Institute of Living, Hartford, Conn., and is clinical professor of psychiatry at Yale.

Dr. Braceland was formerly head of the section of psychiatry of the Mayo Clinic, professor of psychiatry at the Graduate School, University of Minnesota, and dean of Loyola University School of Medicine. During World War II, he served in the navy as chief psychiatrist. Besides heading the American Psychiatric Association, he is president for 1957 of the Association for Research in Nervous and Mental Disease and chairman for the same year of the National Health Forum. He is past president of the American Board of Psychiatry and Neurology.

SAMUEL R. LEHRMAN, M. D. Dr. Lehrman, who joined the editorial board of THE PSYCHIATRIC QUARTERLY late last summer, contributes his paper in the present Freud memorial issue at the invitation of Newton Bigelow, M. D., editor. He is a psychiatrist and psychoanalyst in private practice in New York City and was formerly, for a number of years, in the medical service of the New York state hospital system. More extensive biographical notes will be found in the "News and Comment" section of this issue, where his appointment as associate editor of THE QUARTERLY is announced.

LAWRENCE C. KOLB, M. D. Dr. Kolb is director of the New York State Psychiatric Institute, New York, N. Y. His Hutchings Memorial Lecture, the eighth of a series, was selected for the Freud centennial issue because it reviews psychotherapeutic evolution from the psychoanalytic frame of reference developed by Sigmund Freud. Dr. Kolb, born in Baltimore, is a graduate of Trinity College, Dublin University, and a graduate in medicine of the Johns Hopkins University. He is professor of psychiatry and executive officer of the department of psychiatry at Columbia University College of Physicians and Surgeons and is in private practice in psychoanalysis. He holds American Board of Psychiatry and Neurology certificates in both psychiatry and neurology.

Dr. Kolb became head of the New York State Psychiatric Institute in 1954, leaving positions as consultant in psychiatry at the Mayo Clinic and associate professor of psychiatry at the Mayo Foundation, Graduate School

of Medicine, University of Minnesota. He has taught both neurology and psychiatry, has been in the private practice of both, and has been director of the research division of mental hygiene in the United States Public Health Service. During World War II, he served as commander in the naval medical corps and later was active in the work of the National Research Council.

Besides being a fellow of the American Psychiatric Association, Dr. Kolb is a member of the American Psychoanalytic Association, the American Neurological Association, the Association for Research in Nervous and Mental Diseases, and a fellow or member of numerous other professional organizations. Dr. Kolb is married and has three children.

S. H. POSINSKY, Ph.D. Sollie Henry Posinsky is a psychoanalytically-oriented anthropologist, member of a scientific specialty for which Freud trained the first field workers. A graduate of the New School for Social Research, he obtained his doctor's degree from Columbia University. His interest was turned to anthropology while he was serving with the navy in World War II and was stationed among primitive peoples in the western Pacific. His particular interests include personality and culture, magic and ritual, and ethnological theory. He has published papers and reviews in the *American Imago*, the *Journal of American Folklore*, *Science*, and other scientific journals. Born in New York City, he is living there at present and teaching at Rutgers University at Newark, N. J. He previously taught at Columbia and at Queens College. Dr. Posinsky is married and has two children.

SIDNEY MALITZ, M. D. Dr. Malitz is head of the department of experimental psychiatry at the New York State Psychiatric Institute and acting principal research psychiatrist there. A graduate of the Chicago Medical School in 1946, he followed two years of internship with a two-year residency at the Psychiatric Institute, which he completed in 1951. He was then appointed senior research psychiatrist there, but was on duty with the armed services from 1952 until 1954, when he worked at the Walter Reed Army Institute of Research in Washington in studies of brain-injured patients and the effects of drugs on behavior. He returned to the Psychiatric Institute in 1954 and was promoted to his present position in 1956.

Dr. Malitz' present research interests are primarily in psychopharmacology and psychosurgery, but he is interested also in psychoanalytic investigative techniques and is a candidate for a certificate in psychoanalytic

medicine from the Columbia University Psychoanalytic Clinic for Training and Research. He is an assistant in psychiatry at the Columbia University College of Physicians and Surgeons and holds a number of attending and visiting appointments. He is certified in psychiatry by the American Board of Psychiatry and Neurology and has a private practice.

Dr. Malitz is author or co-author of a number of papers concerning language and behavioral changes in brain-damaged patients, the effects of tranquilizers, and of drugs mimetic of psychoses. He is a member of the American Psychiatric Association and of numerous other professional organizations.

PAUL H. HOCH, M. D. Dr. Hoch has been commissioner of mental hygiene of New York State since 1955, a position to which he was appointed from that of principal research scientist in psychiatry at the New York State Psychiatric Institute. Born in Hungary in 1902, he is a graduate of the medical school of the University of Göttingen, Germany, in 1926. He interned at Göttingen University Hospital, served as an assistant physician there and in Switzerland, and was first assistant physician in charge of the outpatient department and of the brain research division of the clinic at the University of Göttingen when he came to the United States in 1933. Dr. Hoch was on the staff of Manhattan (N. Y.) State Hospital for nine years, in charge of shock treatment, when he left to serve with the War Shipping Administration and act as consultant to the United States Public Health Service during 1942 and 1943. He was assistant clinical psychiatrist at the Psychiatric Institute from 1943 to 1946, senior clinical psychiatrist from 1946 to 1948, and principal research scientist from 1948 until his appointment as commissioner of mental hygiene.

Dr. Hoch has held numerous teaching positions and is now professor of clinical psychiatry, College of Physicians and Surgeons, Columbia University. He is the author or co-author of a large number of books and scientific articles dealing with various aspects of psychiatry and neurology. He is certified in both psychiatry and neurology by the American Board of Psychiatry and Neurology. He is a fellow of the American Psychiatric Association and a fellow or member of various other scientific organizations, besides holding a large number of honorary positions or memberships. He is associate editor of *Psychosomatic Medicine* and the *American Journal of Psychiatry*. Books of which he was co-editor with Joseph Zubin, Ph. D., include: *Depression, Psychiatry and the Law,* and *Psychopathology of Childhood.*

FRED A. METTLER, M. D. Dr. Mettler is an anatomist with wide interests in such other medical fields as psychiatry, neurology, psychosurgery

and forensic medicine. He is professor of anatomy at the College of Physicians and Surgeons, is widely known as a research worker, teacher, writer and editor, and has contributed frequently to this QUARTERLY. He has been director of research for the New York State Department of Mental Hygiene, director of the New York State Brain Research Project, and chairman of the Research Conference Group on Psychosurgery. He has directed a number of other research projects in lobotomy, topectomy and other psychosurgical procedures. He is author or co-author of more than 150 scientific articles and a number of books, and has written, among other subjects, on group psychotherapy and mental hygiene.

A graduate of Clark University, Dr. Mettler has a Ph.D. in anatomy from Cornell and an M. D. from the University of Georgia. He is a member of a number of medical organizations in general and specialized fields and of numerous societies in subjects related to medicine. He is married and has two children.

HERBERT S. CLINE, M. D. Dr. Cline obtained his M. D. degree from Boston University School of Medicine in 1950. He interned at Newton-Wellesley Hospital, Newton, Mass., then was in the armed forces for two years, serving for the last year and a half as a psychiatrist at the 16th Field Hospital. He was a resident physician at Worcester (Mass.) State Hospital the following year, and served the year after that as an assistant physician on the Worcester research service. He was a senior psychiatric resident at Massachusetts General Hospital, Boston, from July 1955 through June 1956, after which he entered the private practice of psychiatry in Boston.

HARRY FREEMAN, M. D. Dr. Freeman was graduated from Harvard Medical School in 1928. He served a two-year internship at Beth Israel Hospital, Boston, then was clinical endocrinologist for 18 years on the research service of Worcester (Mass.) State Hospital. In 1948, he became an associate of the Worcester Foundation for Experimental Biology, Shrewsbury, Mass., dividing his time between duties there and private practice until 1953, when he became director of research at Worcester State Hospital, still retaining his Worcester Foundation affiliation. Dr. Freeman is a diplomate in psychiatry of the American Board of Psychiatry and Neurology and is a member of the American Psychiatric Association.

ROBERT C. HUNT, M. D. Dr. Hunt is assistant commissioner of the New York State Department of Mental Hygiene in charge of community services. These include the local assistance program under the Community

Mental Health Services Act, the department's social service, aftercare, and child guidance clinics, the allocation of federal funds, and the conduct of training programs for community service. Dr. Hunt has spent most of his professional life in the New York state hospital service.

Born in Egypt of American parents in 1905, Robert Hunt attended elementary school in America and Egypt and high school and college in this country. Graduating from Westminster College, Pa., at the age of 20, he was a high school teacher and athletics coach for two years before attending medical school at the University of Pennsylvania, from which he received his M. D. in 1931. After a rotating internship and a year's residency in psychiatry, he served a year as medical intern at Binghamton (N. Y.) State Hospital, then was a fellow in psychiatry at the Institute of the Pennsylvania Hospital, Philadelphia, for another year. From 1935 to 1942, he was on the staff of Rochester (N. Y.) State Hospital, where he rose to the grade of senior assistant physician, before entering the army during World War II for four years of service. He was assistant director at Rochester from 1946 to 1950 and was director at St. Lawrence State Hospital from 1950 to 1952, when he was named assistant commissioner. He has been assigned to community services since 1954.

Dr. Hunt's paper in this issue of THE PSYCHIATRIC QUARTERLY is the result of a fellowship from the World Health Organization for a short study of European mental health programs during 1955. Dr. Hunt is assistant clinical professor of psychiatry at Albany Medical College, is a member of the American Psychiatric Association and other professional organizations, and is the author or co-author of a number of scientific articles on various phases of psychiatry, besides several publications in non-professional journals.

ANTHONY SAINZ, B. A., B. LL., B. Sc., M. D. Born in Havana in 1915, Dr. Sainz received his M. D. degree in 1941 at the University of Havana Medical School.

He has been active in research at the Ministry of Public Health of Cuba, The Finlay Institute for Research of Havana, and the University of Havana Medical School. He was in Europe (U. S. Zone of Occupation, Germany) as a medical director for the UNRRA and had been clinical director at the Mental Health Institute, Cherokee, Iowa, before joining the staff of Marcy (N. Y.) State Hospital in 1955. He is now in charge of the psychopharmacological research unit at Marcy. He has been active in the development and evaluation of phrenotropic drugs since 1950, and has published papers on this, and other psychiatric subjects.

NEWS AND COMMENT

S. R. LEHRMAN, M. D., JOINS QUARTERLY EDITORIAL BOARD

Samuel R. Lehrman, M. D., New York City psychoanalyst and an "alumnus" of the New York state hospital system, has been named an associate editor of the THE PSYCHIATRIC QUARTERLY by the editor, Newton Bigelow, M. D. Dr. Lehrman is widely known as a clinician and writer, and has been active in recent years in training programs for psychoanalytic orientation in psychotherapy. The author of a number of psychiatric and psychoanalytic publications, including papers in this QUARTERLY, he contributed "Reactions to Untimely Death" to the present Freud centenary issue at the particular invitation of the editor.

A native of New York State, Dr. Lehrman served first at Utica State Hospital and later at Creedmoor. He is a graduate of the New York Psychoanalytic Institute and has done postgraduate work at both Columbia and the New York State Psychiatric Institute. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology. Dr. Lehrman is a fellow of the American Psychiatric Association, the American Medical Association and the New York Academy of Medicine. He is a member of the New York Psychoanalytic Society and various other professional organizations, and has been secretary-treasurer of the New York State Hospital Alumni Association for the last three years.

Dr. Lehrman has been on the attending staff of Mount Sinai Hospital, New York City, for 10 years, and has served as chief of clinic of the psychiatry outpatient department and as liaison psychiatrist (in charge) to the medical service. He is associate attending psychiatrist at Hillside Hospital and consulting psychiatrist at Hebrew Union College-Jewish Institute of Religion. Dr. Lehrman's bachelor's degree is from Columbia and his medical degree from the Eclectic Medical College of Cincinnati, Ohio. Service in World War II ranged from assistant chief neuropsychiatric examiner at induction stations to commanding officer and director of therapy of a treatment battalion of a neuropsychiatric regiment at Wakeman General and Convalescent Hospital.

TWO NEW QUARTERLY JOURNALS ESTABLISHED

Publication of two new quarterly journals, the *Journal of Neurochemistry* and the *Journal of Psychosomatic Research,* has been commenced by Pergamon Press of London and New York. Both quarterlies are published in London and both have international editorial boards. That of the *Journal of Neurochemistry* includes representatives of four American institutions,

one of whom is Heinrich B. Waelsch, M. D., of the New York State Psychiatric Institute. The American on the board of the *Journal of Psychosomatic Research* is Harold G. Wolff, M. D. of New York Hospital.

The first issue of the latter journal was in February 1956, with the first issue of the *Journal of Neurochemistry* in May of the same year. The *Journal of Psychosomatic Research* included in its first number, seven scientific articles, an editorial and book reviews. The first number of the *Journal of Neurochemistry* contained 11 original articles. The papers in the first issue of the *Journal of Psychosomatic Research* range from a review: "Emotions and the Peripheral Vaso-Motor System" by Brian Ackner, M. D., to a report of a Rorschach study of the neurodermatoses.

NEW PSYCHIATRIC UNDERTAKINGS BEGIN

The Penn Foundation for Mental Health dedicated its new building in Sellersville, Pa. on November 11, 1956. Kenneth E. Appel, M. D., was the principal speaker at the dedication ceremonies. The foundation is planned as a part of what its sponsors hope will be a noteworthy community medical center.

The medical center of Temple University announced in August 1956 the opening, during the coming winter, of an Institute of Direct Analysis for treatment of schizophrenia. It is being established under the direction of O. Spurgeon English, M. D., head of the Temple University psychiatry department, and has a pledge of $150,000 for support over a three-year period, by the Rockefeller Foundation. John N. Rosen, M. D., New York psychiatrist, has been named associate professor of psychiatry at the Temple Medical Center and is director of the new institution. Besides the intensive treatment of patients, the Institute plans to train therapists for research and treatment in the methods of direct analysis.

The Gralnick Foundation for Research and Treatment of Mental Illness has been created as a public charitable trust under the laws of New York State. Alexander Gralnick, M. D., director of High Point Hospital, Port Chester, N. Y., is a member of the Foundation's board of directors. Besides the advancement of research, the Foundation aims to aid mental hygiene organizations, help schools in the training of psychiatrists (particularly in psychoanalysis), and stimulate medical school and hospital programs.

MEETINGS, CONFERENCES, LECTURES, AND COURSES FOR 1957

The 113th annual meeting of the American Psychiatric Association in Chicago from May 13 to 17 is the outstanding event of professional psychiatric interest scheduled for 1957. Harry C. Solomon, M. D., of Boston,

will take office as president. An American Psychiatric Association regional research meeting will take place in Syracuse, N. Y., April 5 and 6; Marc H. Hollender, M. D., professor and chairman of the department of psychiatry, State University of New York, Upstate Medical Center, Syracuse, will be chairman of the meeting. The topic will be "Research in Affects."

The American Association on Mental Deficiency will hold its 1957 meeting in Hartford, Conn., May 21 through May 25. Chris DeProspo, M. A., of Glen Cove, N. Y., will be installed as the new association president. It will be the organization's eighty-first annual meeting.

The thirty-fourth annual meeting of the American Orthopsychiatric Association will be conducted March 7 through 9 in Chicago, with more than 5,000 persons expected to attend. It will be preceded on March 6 by a round table on world mental health problems, sponsored by the Orthopsychiatric Association and the World Federation for Mental Health, of which Margaret Mead, Ph.D., is president. Luther Woodward, Ph.D., of Brooklyn will give the presidential address at the Orthopsychiatric Association meeting, and Reginald Lourie, M. D., of Washington will take office as new president.

The annual meeting of the American Psychopathological Association will take place February 22 and 23 in New York City. The topic of the symposium is: "Addiction and Habituation"; the results will be published in the course of the year.

The 1957 National Health Forum will be conducted in Cincinnati, Ohio, March 20 through March 22, with its subject devoted to mental health. Francis J. Braceland, M. D., president of the American Psychiatric Association, is chairman of the committee planning the forum program. The forum is one event of a week's activities including other meetings and projects sponsored by the National Health Council.

Yale University's fifteenth annual Summer School of Alcohol Studies has been announced as from July 1 through July 27. The school is interdisciplinary, admitting clergymen, educators and others, besides members of the medical and associated disciplines; its enrollment is limited to 200.

Lectures of professional interest include two at the North Shore Health Resort, Winnetka, Ill., "Premarital Counseling," by Emily H. Mudd, Ph.D., on March 6, and "Problems of Adulthood," by C. Knight Aldrich, M. D. on March 27. Frieda Fromm-Reichman, M. D., will deliver the fifth annual Karen Horney lecture on March 27 in New York City on "Psychotherapy of Schizophrenics." A symposium on preliminary findings in the treatment of neuropsychiatric disorders with the "sedac" will be conducted by the Eastern Psychiatric Research Association on February 14 at the New York Academy of Sciences, New York City. David J. Impastato, M. D., of New York City is president of the association.

MENTAL HYGIENE DEPARTMENT CHANGES ANNOUNCED

Isaac N. Wolfson, M. D., has become senior director of Letchworth Village, Thiells, N. Y., and Frank R. Henne, M. D., has been named director of Newark State School in two of a number of personnel changes in the New York State Department of Mental Hygiene. Dr. Wolfson was promoted from director of Newark to the senior position at Letchworth; and Dr. Henne was promoted from assistant director of Harlem Valley State Hospital to succeed Dr. Wolfson at Newark.

In an important central office change, Robert E. Patton has been named director of the bureau of statistics of the Department of Mental Hygiene in a provisional appointment, to succeed Benjamin Malzberg, Ph.D., who retired in September 1956 to direct a five-year research project on demographic and other aspects of mental disease for the National Institute of Mental Health. More extensive notes on the change in the statistical bureau and on the appointments of Drs. Wolfson and Henne appear in THE PSYCHIATRIC QUARTERLY SUPPLEMENT, Part 1, 1956.

Alvin I. Goldfarb, M. D., psychiatrist and psychoanalyst of Bayside, N. Y., has been named to a new position, created by the 1956 legislature, consultant on psychiatric services for the aged in the Department of Mental Hygiene. The appointment was announced on October 11 by Commissioner of Mental Hygiene Paul H. Hoch, M. D. Dr. Goldfarb, a graduate of the medical school of the Johns Hopkins University in 1939, has done research in neurophysiology and neurosurgery, has held hospital residencies in neuropathology and neurology, and has served in the Connecticut state hospital system. His certificate in psychoanalytic medicine is from the Psychoanalytic Institute for Training and Research at Columbia University. Since 1949, he has been chief of the department of neurology and psychiatry of the Hospital and Home for Infirm Hebrews, New York City, and has held a number of attending and teaching appointments. He is a diplomate in neurology of the American Board of Psychiatry and Neurology, is a member of the American Psychiatric Association, the Gerontological Society and other professional groups, and is a fellow of the American Academy of Neurology.

Another appointment of importance to the department is that of Paul Robinson of Schenectady to be assistant director of the Interdepartmental Health Resources Board. It was announced by Commissioner of Mental Hygiene Hoch, who is also chairman of the board. Mr. Robinson has been, for the last two years, junior administrative assistant in the office of public health education of the New York State Department of Health. The Interdepartmental Health Resources Board was created by the 1956 legislature to co-ordinate interdepartmental programs in health, mental health and vocational rehabilitation. Besides the commissioner of mental hygiene, the

board includes the commissioners of correction, health, education, labor and social welfare, and the chairman of the division of parole, the workmen's compensation board, and the joint hospital survey and planning commission. Dr. I. Jay Brightman is executive director.

HELEN YARNELL, CHILDREN'S PSYCHIATRIST, DIES AT 52

Helen Yarnell, M. D., New York City psychiatrist, widely recognized as an authority on the behavior disorders of children, died in New York City on September 8, 1956 at the age of 52. She had been associated with Bellevue Hospital and had been senior psychiatrist at the Bronx Center of the city's Board of Education bureau of child guidance. She was co-author with Nolan D. C. Lewis, M. D., of a well-known study of pyromania, *Pathological Firesetting.*

DRUG COMPANY FOUNDATION AIDS MENTAL HEALTH

The National Association for Mental Health has received a new $25,000 grant from the Smith, Kline and French Foundation of Philadelphia for its program of a "Citizens Army Against Mental Illness." A previous Smith, Kline and French grant resulted in the affiliation of seven new mental health associations, bringing the national association total to 40.

NEW YORK DIRECTORS STUDY IN GREAT BRITAIN

In a trip made possible by a grant from the Milbank Memorial Fund, directors of five New York State mental hospitals and Assistant Commissioner Robert C. Hunt, M. D., of the New York State Department of Mental Hygiene are making a study in January and February 1957 of community and mental hospital relationships in Great Britain. The trip results in part from Dr. Hunt's previous tour, made in 1955 under a World Health Organization fellowship, and reported in an article in this issue of THE PSYCHIATRIC QUARTERLY. Directors making the study are: Nathan Beckenstein, M. D., of Brooklyn, Hyman Pleasure, M. D., of Middletown, Francis J. O'Neill, M. D., of Central Islip, Herman Snow, M. D., of St. Lawrence and Christopher F. Terrence, M. D., of Rochester.

POSTGRADUATE TRAINING PROGRAM INSTITUTED

An important educational project in the New York State Department of Mental Hygiene got under way in September 1956 with the opening of a program for advanced training of state institution psychiatrists with

the co-operation of the State University Medical School at Brooklyn. The program, giving comprehensive postgraduate training in psychiatry, is open to the staffs of six downstate institutions. A similar program for the upstate institutions is planned in co-operation with the State University Medical School at Syracuse.

ALFRED C. KINSEY IS DEAD AT 62

Alfred C. Kinsey, Sc.D., whose work on sexual behavior created a storm of controversy in psychiatric circles over the last eight years, died in Bloomington, Ill., August 25, 1956. Dr. Kinsey was a zoologist and research worker. His two controversial volumes were *Sexual Behavior in the Human Male,* published in 1948, and *Sexual Behavior in the Human Female,* brought out in 1953. He had been ill for some months and had suspended active work on several new research projects when he succumbed to the effects of a heart ailment and pneumonia.

V. A. HOSPITAL ANNOUNCES RESIDENCIES

The Veterans Administration hospital at Lyons, New Jersey, has announced that residencies in psychiatry for one- to three-year periods are now available. The hospital's training program is under the direction of New York Medical College.

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